

FILED APR. 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10041**
2573
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY MO	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS MO		c. LENGTH OF STAY (In this place) 4 1/2 YRS.	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		d. FULL NAME OF HOSPITAL OR INSTITUTION 1871 MADISON STR. 1	
d. STREET ADDRESS 1871 MADISON STR.		e. ADDRESS (If rural, give location) 0	
3. NAME OF DECEASED (Type or Print) a. (First) NICHOLAS		b. (Middle) JOHN	
c. (Last) FOLLMER		4. DATE OF DEATH (Month) (Day) (Year) MCH. 20-1949	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH NOV. 7TH 1895
9. AGE (In years last birthday) 53		IF UNDER 1 YEAR Days	IF UNDER 24 Hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR SUPPL. DEPT.		10b. KIND OF BUSINESS OR INDUSTRY EDUCATION	
11. BIRTHPLACE (State or foreign country) AUSTRIA-GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME JOHN FOLLMER		13b. MOTHER'S MAIDEN NAME ANNA BEISCH	
14. NAME OF HUSBAND OR WIFE AGNES FOLLMER.		17. INFORMANT'S SIGNATURE OR NAME/871 ADDRESS Mrs. Agnes Follmer, 1871 Madison	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
18. CAUSE OF DEATH Enter one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiovascular ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 1871 DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 442X	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) NO		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) St. Louis Mo	
21c. (CITY) TOWN, OR TOWNSHIP (COUNTY) (STATE) St. Louis Mo MO			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 19 48 to Mar 20 1949 , that I last saw the deceased alive on 3 20 1949 , and that death occurred at 5:25 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE D. J. Thegal M.D. (Degree or title)		23b. ADDRESS 1875 Madison	
23c. DATE SIGNED 3/24/49			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE MCH 23-49	
24c. NAME OF CEMETERY OR CREMATORY CALVARY CEM.		24d. LOCATION (City, town, or county) (State) ST. LOUIS MO.	
DATE REC'D BY LOCAL REG. MAR 22 1949		REGISTRAR'S SIGNATURE J. A. Lasater	
25. FUNERAL DIRECTOR'S SIGNATURE Brockland Und. Co.		ADDRESS 1827 HOGAN ST.	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St. Louis, Mo

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.