

FEDERAL BUREAU OF INVESTIGATION FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041472

FILED VS. NOV 17 1959 316

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 426

STATE FILE NUMBER

ENDED

| | | | | | |
|--|---|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>ST FRANCIS</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Francis Twp. FARMINGTON</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>STATE Hosp. No 4</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis County</u> c. CITY OR TOWN <u>Lemay, Missouri</u> d. STREET ADDRESS <u>904 Lemay Ferry Rd.</u> | | |
| 3. NAME OF DECEASED (Type or print) First <u>IRENE</u> Middle <u>CHRISTINE</u> Last <u>BERGER</u> | | | 4. DATE OF DEATH Month <u>Nov</u> - Day <u>3</u> - Year <u>1959</u> | | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>Sept-30-1911</u> | 9. AGE (last birthday) <u>48</u> | IF UNDER 1 YEAR Months <u>1</u> Days <u>4</u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> | | 11. BIRTHPLACE (City and state or country) <u>St. Louis Co, Mo</u> | |
| 13a. FATHER'S NAME <u>HENRY FRIEDEMEYER</u> | | 13b. MOTHER'S MAIDEN NAME <u>CHRISTINE BAUER</u> | | 14. NAME OF HUSBAND OR WIFE _____ | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>ADELL SCHICKE</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pulmonary tuberculosis</u> - - - - - <u>5 yrs.</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Dementia Praecox Psychosis for about 20 yrs.</u> | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from <u>Jan. 4, 1946</u> to <u>Nov. 3, 1959</u> and last saw <u>her</u> live on <u>Nov. 3, 1959</u> Death occurred at <u>2:45 P. M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <u>[Signature]</u> | | | 22b. ADDRESS <u>State Hospital No. 4 Farmington, Missouri</u> | | 22c. DATE SIGNED <u>11-6-59</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE <u>NOV-6-1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>PARK LAWN Cem.</u> | | 23d. LOCATION (City, town, or county) (State) <u>Lemay Mo</u> |
| 24. FUNERAL DIRECTOR /ADDRESS <u>FEY FUNERAL HOME, MEHLVILLE Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>NOV. 6, 1959</u> | | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6961 8 T AON SA

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *V E Morris*

Licensed Embalmer No. 3360

P. O. Address St Louis

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.