

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-008632

FILED VS FEB 23 1960

Registration District No.

Primary Registration District No.

Registrar's No.

2 1231

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Length of stay in 1b <u>68 YRS.</u>	c. CITY OR TOWN <u>ST. LOUIS</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DE PAUL HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3917 N. 20TH ST.</u>	
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>(HARRY)</u> Last <u>MOLKENBUR</u>			4. DATE OF DEATH Month <u>FEB.</u> Day <u>1</u> Year <u>1960</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/22/1891</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WIRE ROPE CO.</u>		11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>JOHN MOLKENBUR</u>		13b. MOTHER'S MAIDEN NAME <u>UNK.</u>	
14. NAME OF HUSBAND OR WIFE <u>MAY MOLKENBUR</u>		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>488-07-3098A</u>	
17. INFORMANT <u>MAY MOLKENBUR</u>		Address <u>3917 N. 20TH ST.</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>art. sclerotic carus cerebral vas in</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1yr</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>422.1</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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. _____	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 7-6-59 to 2-1-60 and last saw ^{her}him alive on 2-1-60
Death occurred at 3:20 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)
Wayne J. Smith M.D.

22b. ADDRESS
100 No Euclid

22c. DATE SIGNED
2-2-60

23a. BURIAL, CREMATION, REMOVAL (Specify)
REMOVAL

23b. DATE
FEB. 4, 1960

23c. NAME OF CEMETERY OR CREMATORY
ZION CEMETERY

23d. LOCATION (City, town, or county) (State)
ST. LOUIS COUNTY MO.

24. FUNERAL DIRECTOR
SUED MEYERSONS

ADDRESS
3934 N. 20TH

25. DATE RECD. BY LOCAL REG.
FEB 3 1960

26. REGISTRAR'S SIGNATURE
Earl Smith M.D.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Clarence M. Billow

Licensed Embalmer No. 4375

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.