

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046289

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 5195318 Primary Registration District No. 1003 Registrar's No. 11974

STATE FILE NUMBER

AMENDED

FILED ON ST-27050 X0-2 983 567

DATE AMENDED

INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI (6)</u>		Length of stay in lb <u>45 DAYS</u>	c. CITY OR TOWN <u>St. Louis</u> <u>Lemay (25)</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VAH, 915 NO. GRAND AVE.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1217 WACHTEL Ave.</u>

3. NAME OF DECEASED (Type or print) First Middle Last <u>PAUL A. FOELLER</u>			4. DATE OF DEATH Month Day Year <u>Dec. 21, 1961</u>			
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</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>2/24/96</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanical Supt.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>National Lead</u>	11. BIRTHPLACE (City and state or country) <u>LEMAY, MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>ANTON FOELLER</u>	13b. MOTHER'S MAIDEN NAME <u>Julia Rensing</u>	14. NAME OF HUSBAND OR WIFE <u>CLARA FOELLER</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>NW-I</u>	17. INFORMANT Address <u>CLARA FOELLER (WIDOW) SEE #2</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>PNEUMONIA</u>		<u>3 DAYS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>MULTIPLE MYELOMA</u>	<u>1 YEAR</u>
	DUE TO (c) <u>203x</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE WITH MYOCARDIAL INFARCT</u>	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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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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
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21. I attended the deceased from <u>VA</u> <u>11/6/61</u> to <u>12/21/61</u> and last saw <u>him</u> alive on <u>7:00 AM</u> Death occurred at <u>7:00 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (In care or title) <u>Arnold M. Goldman, Doctor</u>	22b. ADDRESS <u>M.D. VAH, ST. LOUIS, MO.</u>	22c. DATE SIGNED <u>12/21/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Dec. 26, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Jefferson Barracks, Mo.</u>
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24. FUNERAL DIRECTOR <u>Fendler Und. Co. 7420 Michigan Ave.</u>	25. DATE RECD. BY LOCAL REG. <u>(11) DEC 22 1961</u>	26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>
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SHOULD READ

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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 _____
Signature of Student Embalmer

Signed W G Peterson

Licensed Embalmer No. 3767

P. O. Address 7420 Mich

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.