No. 2
—2-43
5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 34497

FILED NOV 8 1945

Registration District No. 376 — Primary Registration District No. 3059 — Registrar's No. 212

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town Bonne Terre
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bonne Terre Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether
In this community ____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St Francois
(c) City or town Bonne Terre
(If outside city or town limits, write "RURAL")
(d) Street No. Jackson
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME ELIZABETH MARGARET FALK
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓
4. Sex F
5. Color or race W
6. (a) Single, widowed, married divorced Married
6. (b) Name of husband or wife Joseph Falk
6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased Sept. (Month) 18 (Day) 1876 (Year)

8. AGE: Years 69 | Months 1 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Housewife
11. Industry or business ____
MOTHER
12. Name Adam Motsch
FATHER
13. Birthplace ____ (City, town, or county) Germany (State or foreign country)
MOTHER
14. Maiden name Catherine Franzen
15. Birthplace ____ (City, town, or county) Germany (State or foreign country)
16. (a) Informant Jos Falk
(b) Address St Louis Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 31, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation St Joseph's Cem Bonne Terre
18. (a) Signature of funeral director Peacham Hydle
(b) Address 318 Benham Bonne Terre Mo.
19. (a) 11-5-45 (Date received local registrar) (b) Esther Rudloff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 28th year 1945 hour 9 minute 20 A.M.
21. I hereby certify that I attended the deceased from October 22, 1945, to Oct. 28, 1945, that I last saw her alive on Oct. 28, 1945, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary heart disease	several years
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death): Contusion & laceration of forehead, right cheek & both eyes	6 days

Major findings:
Of operations: SUPPLEMENTARY INFORMATION REQUESTED
Of autopsy: (Possible secondary cause)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident
(b) Date of occurrence Oct. 22, 1945
(c) Where did injury occur? Bonne Terre, St. Francois Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Highway junction near Bonne Terre
While at work? No (Specify type of place) (e) Means of injury Auto accident
23. Signature M. T. Hawk, M.D. (M. D. or other)
Address Bonne Terre Mo. Date signed 11/5/45

1317

(Licensed Embalmer's Statement on Reverse Side)

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 4

District File Number 1145-1296

Date Filed 11-8-45

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.....

..... Registered Apprentice No.....

working under my personal supervision.

Signed C. J. Claywell

Licensed Embalmer No. 3706

P. O. Address Banner Elk N. C.

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

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

No. 2B
—5-43
X36930

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. N o

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 212

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

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town Bonne Terre
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Elizabeth M Falk
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept 18 1876 (Month) (Day) (Year)
8. AGE: Years 69 Months 1 Days | If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 28 year 1945 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to H	
Due to [illegible]	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Possible contributory cause ?

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence Intersection U.S. 61 highway
(c) Where did injury occur? 10/22/45. at Bonne Terre, Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Highway - above. Collision of auto (Specify type of place)
While at work? No (e) Means of injury with panel truck
23. Signature M. L. Haw, J. (M. D. or other) M.D.
Address Bonne Terre, Mo. Date signed 11/15/45.

34497