

7-39
K21492

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33134
Registrar's No. 1853

Registration District No. 284 Primary Registration District No. 200

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town Overland
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
9533 Hawthorne Ave
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 20
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Alice Fetsch
 3. (b) If veteran, name war No 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced widowed
 6. (b) Name of husband or wife Ferdinand Fetsch 6. (c) Age of husband or wife if alive years
 7. Birth date of deceased August 13 1878
 (Month) (Day) (Year)

8. AGE: Years 62 Months 1 Days 18 If less than one day hr. min.

9. Birthplace Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business None

MOTHER FATHER

12. Name Thomas Coleman
 13. Birthplace Ireland
 (City, town, or county) (State or foreign country)
 14. Maiden name Mary Fry
 15. Birthplace Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant Miss. Catherine Fetsch
 (b) Address 9533 Hawthorne Ave.,

17. (a) Burial (b) Date thereof Oct 3 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Jos. W. Clark
 (b) Address 1125 Hodiamont Ave.

19. (a) OCT - 1 1940 (b) A.R. Meyer
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
 (c) City or town Overland
 (If outside city or town limits, write "RURAL")
 (d) Street No. 9533 Hawthorne Ave
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 1
 year 1940 hour 5 minute 35 A. M.

21. I hereby certify that I attended the deceased from April 20, 1936
 to Oct 1st, 1940
 that I last saw her alive on Oct 1st, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis Duration 6 yrs

Due to 131
 Due to 131
 Other conditions Chronic nephritis 5 yrs
 (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
 Of operations
 Of autopsy not performed
 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)
 (b) Date of occurrence
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work? (Specify type of place) (e) Means of injury

23. Signature Arnold H. Warger (M. D. or other)
 Address 2900 St. Clair Rd Date signed 10/1/40

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

Dr Wurzer

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 _____

Licensed Embalmer No. **3225**

P. O. Address **1125 Hodiament Ave.**

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, above space should be left blank.