

FILED MAY 20 1944

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 16342

Registrar's No. 4407

1. PLACE OF DEATH:

(a) County.....  
(b) City or town..... St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... 6 days  
(Specify whether  
In this community.....  
years, months or days)

3. (a) PRINT FULL NAME Oscar Fox

3. (b) If veteran, name war.....  
3. (c) Social Security No. None

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Margaret Fox  
6. (c) Age of husband or wife if alive years 11 1869

7. Birth date of deceased. August  
(Month) (Day) (Year)

8. AGE: Years 74 Months 9 Days 0  
If less than one day hr. min.

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

10. Usual occupation Machinist

11. Industry or business

12. Name William Fox

13. Birthplace Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Anna Caroline

15. Birthplace Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Emma Howell

(b) Address 4105 Turner Ave.

17. (a) Burial (b) Date thereof. 5/13/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Stroot-Carroll

(b) Address 4600 Natural Bridge Blvd.

19. (a) MAY 12 1944 (b) J. F. Bredsch  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis (If outside city or town limits, write "RURAL")  
(d) Street No. 5156 Maple Ave. (If rural, give location)  
(e) Citizen of foreign country? (Yes or No) 0  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11th  
year 1944 hour 6 minute 05 P.M.

21. I hereby certify that I attended the deceased from May 5th  
19 44 to May 11th 19 44

that I last saw h im alive on May 11th 19 44  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Lung  
Duration

Due to.....

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....

Of autopsy.....

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).....

(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 J. Kreyenbush (M. D. or other) M.D.

Address 1515 Lafayette Date signed 5/12/44

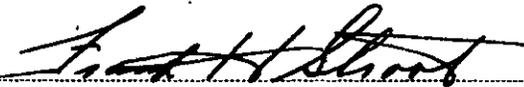
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

844

**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. 2265-

P. O. Address 46<sup>th</sup> St Bridge on

**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, fact should be so stated above.**