S. No. 2
M—8-43
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P I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 25 1945

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 278

Primary Registration District No. 1003

Registrar's No. 462

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Christian Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 0 (Specify whether
In this community: years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County:

(c) City or town: St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No.: 4206 Labadie Ave.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: Helen Fox

3. (b) If veteran, name war:

3. (c) Social Security No. 490-01-864

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Single

6. (b) Name of husband or wife:

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: September 13 1901 (Month) (Day) (Year)

8. AGE: Years 43 Months 4 Days 2 If less than one day: hr. min.

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

10. Usual occupation: Clerk

11. Industry or business:

FATHER 12. Name: John Fox

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

MOTHER 14. Maiden name: Mary Burke

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

16. (a) Informant: John Fox

(b) Address: 4205 Shreve Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1/18/45 (Month) (Day) (Year)

(c) Place: burial or cremation: Calvary Cem.

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

(b) Address: 4600 Natural Bridge Ave.

19. (a) JAN 16 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 15 year 1945 hour 7 minute A M.

21. I hereby certify that I attended the deceased from Jan. 5th, 1938 to Jan. 14th, 1945 that I last saw her alive on Jan 14th, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Prim.: Chronic generalized Arthritis Deformans 7 years.

Due to: Chr. Cardo-Vascular Renal disease - with hypertension Five years

Due to: Sec: Uremia - Uremic Coma & Uremic Convulsions 10 days

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

Major findings:
Of operations:
Of autopsy: Yes

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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: [signature] (M. D. or other)

Address: 3718 Jennings Rd Date signed:

(Licensed Embalmer's Statement on Reverse Side)

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 Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address.....

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.