S. No. 2
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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 MAR 3 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

4214

State File No. 1533

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County

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

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

(d) Length of stay: In hospital or institution 8 days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 5604 Waterman Avenue
(If rural, give location)

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

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3. (a) PRINT FULL NAME Charles Ross Fife

3. (b) If veteran, name war No

3. (c) Social Security No. 491-14-6345

4. Sex Male

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 29, 1855 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
89	4	14	hr. min.

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

10. Usual occupation Credit Manager

11. Industry or business Gaylord Container Corporation

FATHER
12. Name Wm. G. Fife.
13. Birthplace Mo. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sara Jane Ross
15. Birthplace Scott Co., Mo. (City, town, or county) (State or foreign country)

16. (a) Informant E. J. Spiegle,
(b) Address Cotton Belt Bldg.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 15, 1945. (Month) (Day) (Year)
(c) Place: burial or cremation Bellefontaine Cemetery

18. (a) Signature of funeral director Robert J. Ambruster
(b) Address Clayton Rd. at Concordia Lane,

19. (a) FEB 16 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 13 year 1945 hour 3:30 minute P. M.

21. I hereby certify that I attended the deceased from Feb. 6, 1945 to Feb. 13 1945 that I last saw him alive on February 13, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to Bronchopneumonia	10 Days
Due to + Uremia	?
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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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 Arnold S. Flex (M. D. or other) M.D.
Address 2832 S. Kingshighway, Date signed 2-15-45

(Licensed Embalmer's Statement on Reverse Side) St. Louis, Mo.

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. 1994

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.