

No. 2
12-45
17-39
X47070

FILED DEC 22 1948 2
Registration District No.

Primary Registration District No. **5594**

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

1. PLACE OF DEATH:

(a) County **JEFFERSON**

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

(c) Name of hospital or institution:
St. Joseph's Hill INFIRMARY
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **23 DAYS** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **JOSEPH FEY**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **None**

4. Sex **M** 5. Color or race **W**

6. (a) Single, widowed, married, divorced **SINGLE**

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

7. Birth date of deceased **JULY 14 1859**
(Month) (Day) (Year)

8. AGE: Years **89** Months **5** Days **0** If less than one day hr. min.

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

10. Usual occupation **GARDENER**

11. Industry or business

12. Name **JACOB FEY**

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

14. Maiden name **MARY ANN LABOT**

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

16. (a) Informant **Primitiv Clack, M.D.**
(b) Address **St. Joseph's Hill Inf.**

17. (a) **Burial** (b) Date thereof **12/17/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Peter's Cemetery**

18. (a) Signature of funeral director **Louis H. Bopp, M.D.**
(b) Address **131 W. Argonne Dr. Kirkwood**

19. (a) **Dec 16, 48** (b) **Phil. J. Kirk**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town **KIRKWOOD**
(If outside city or town limits, write "RURAL")

(d) Street No. **UNKNOWN**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **DECEMBER** day **14**
year **1948** hour **6** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **NOVEMBER 23**, 19**48**, to **DECEMBER 13**, 19**48**.
that I last saw him alive on **DECEMBER 13**, 19**48**
and that death occurred on the date and hour stated above.

Immediate cause of death **CARDIAC INSUFFICIENCY**
Duration

Due to **M. YOCARDITIS**

Due to **GENERALIZED ATHEROSCLEROSIS**

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy **93**

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

22. If death was due to external cause, 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 **Primitiv Clack M.D.** (M. D. or other) **M.D.**
Address **3155 No. Vandeventer** Date signed **12/14/48**

RECEIVED
District Health Officer No. 9,
District of Columbia
Date Filed
DEC 21 1948

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 Felix Demand

Licensed Embalmer No. 3034

P. O. Address Kirkwood 22 m

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.