

FILED JAN 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2659

202

BIRTH NO. 48-82.951 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY XXXXXX | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. LENGTH OF STAY (in this place) | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | d. STREET ADDRESS (If rural, give location) St. John's Hospital |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital | | | d. STREET ADDRESS (If rural, give location) St. John's Hospital | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Cheryl b. (Middle) Ann c. (Last) Fernandez | | | 4. DATE OF DEATH (Month) (Day) (Year) Jan 7, 1949 | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) infant | 8. DATE OF BIRTH Dec. 28, 1948 | | 9. AGE (In years last birthday) IF UNDER 1 YEAR Days 10 IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Mo. | | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13a. FATHER'S NAME Art. Fernandez | | 13b. MOTHER'S MAIDEN NAME Lucille Schoene | | 14. NAME OF HUSBAND OR WIFE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Art Fernandez, 6723 Vermont | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. | | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature Birth 6 1/2 months INTERVAL BETWEEN ONSET AND DEATH ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 159 776 | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? | | |
| 22. I hereby certify that I attended the deceased from 12/28 , 19 48 , to 1/7 , 19 49 , that I last saw the deceased alive on 1/7 , 19 49 and that death occurred at _____ m., from the causes and on the date stated above. | | | | | |
| 23a. SIGNATURE (Degree or title) J. B. Lasater M.D. | | | 23b. ADDRESS 5521 S. Bldg | | 23c. DATE SIGNED 1/7/49 |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 24b. DATE 1/8/49 | 24c. NAME OF CEMETERY OR CREMATORY Mount Hope Cemetery | 24d. LOCATION (City, town, or county) (State) Lemay 23, Mo. | |
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE J. B. Lasater | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Gendle & Co 7426 Michigan Ave. | | | |

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Gruneto
5521 S. Broadway

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.....

Student Embalmer No.

working under my personal supervision.

v

Student

Student Embalmer

Signed.....

W. E. Embel

Licensed Embalmer No.

P. O. Address.....

W. E. Embel

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: