

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

24771

State File No. ....

FILED JUL 30 1949

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6355**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>St. Louis, Missouri.</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <b>3680 Bellerive</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital #1.</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>HERMAN</b> b. (Middle) <b>...</b> c. (Last) <b>FABRICIUS</b>			4. DATE OF DEATH July 20th, 1949		
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	
8. DATE OF BIRTH <b>Sept. 19, 1876</b>		9. AGE (Years, Months, Days) <b>72</b>		10. IF UNDER 1 YEAR IF UNDER 48 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>XXX</b>		11. BIRTHPLACE (State or foreign country) <b>St. Louis, Mo.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					

13a. FATHER'S NAME <b>Philip Fabricius</b>		13b. MOTHER'S MAIDEN NAME <b>Caroline Marlene</b>		14. NAME OF HUSBAND OR WIFE <b>Dora A.</b>	
---	--	--	--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Dora A. Fabricius, 3680 Bellerive</b>	
---	--	-------------------------	--	---	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Infarction of Myocardium</b> ANTECEDENT CAUSES <b>Coronary Arteriosclerosis</b> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

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) <b>944</b>	
--	--	--	--	---	--

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? <b>4221</b>	
--	--	--	--	--	---	--

22. I hereby certify that I attended the deceased from **6/26/49**, 19\_\_\_, to **6/20/49**, 19\_\_\_, that I last saw the deceased alive on **6/20/49**, 19\_\_\_, and that death occurred at **1:32pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>John W. ... M.D.</b>		23b. ADDRESS <b>1515 Lafayette Ave.,</b>		23c. DATE SIGNED <b>7/20/49</b>	
---	--	---	--	------------------------------------	--

24a. BURIAL CREMATION REMOVAL (Specify) <b>Cremation</b>		24b. DATE <b>7/23/49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Missouri Crematory</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
---	--	-----------------------------	--	---	--	--	--

DATE REC'D BY LOCAL REG. <b>JUL 22 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Lasater</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wacker-Heldahl &amp; Co. 3634 Gravois</b>	
--	--	---	--	--	--

(Licensed Embalmer's Statement on Reverse Side)

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

**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.

Student .....  
Student Embalmer

Signed Robert Wheeler

Licensed Embalmer No. 3178

P. O. Address St Louis mo

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.