

FILED FEB 11 1950 STANDARD CERTIFICATE OF DEATH

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **3069** Registrar's No. **304**

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Randolph	
b. CITY OR TOWN ST. LOUIS HEIGHTS		c. CITY OR TOWN Chester	
c. LENGTH OF STAY (In this place) 1 Day		d. STREET ADDRESS (If rural, give location) R.F.D. No 2	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Marys Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Alta b. (Middle) Fey c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 2-4-1950		
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5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 10-6-1897		9. AGE (In years last birthday) 50		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (State or foreign country) Chester / Illinois			12. CITIZEN OF WHAT COUNTRY USA		
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13a. FATHER'S NAME Ed Mueller			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE William Fey		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME William Fey		ADDRESS Chester Ill	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PULMONARY EMBOLISM, LEFT LUNG ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) PNEUMATIC HEART DISEASE MITRAL STENOSIS DUE TO (c) CONGENITAL HEART DISEASE / INTER VENTRICULAR SEPTAL DEFECT 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS. UNDETERMINED FROM BIRTH	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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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)	
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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? 4th floor	
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22. I hereby certify that I attended the deceased from **2/3**, 19**50**, to **2/4**, 19**50**, that I last saw the deceased alive on **2/3**, 19**50**, and that death occurred at **5:15 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Thomas W. Parker M.D.		23b. ADDRESS 4660 Maryland, St. Louis, Mo		23c. DATE SIGNED 2/4/50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2-6-50		24c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		24d. LOCATION (City, town, or county) (State) Randolph Ill	
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DATE REC'D BY LOCAL FEB 4 1950		REGISTRAR'S SIGNATURE Herbert R. Dwyer, M.D.		FURNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc		ADDRESS	
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(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

J Allen Davis Jr

Licensed Embalmer No. 4053

P. O. Address St Louis 10 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.