

FILED MAY 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18178

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1308

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO</u> b. COUNTY				
b. CITY (If outside corporate limits, write RURAL and give township) <u>St Louis Mo</u>		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis</u> 2269		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1618 N. 19th St</u>		d. STREET ADDRESS (If rural, give location) <u>1618 N. 19th St 0</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Thomas</u> b. (Middle) <u>J.</u> c. (Last) <u>Fortune</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5 11 50</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		
8. DATE OF BIRTH <u>April 10-1875</u>		9. AGE (In years last birthday) <u>75</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		
14. NAME OF HUSBAND OR WIFE <u>Clara Fortune</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		
17. INFORMANT'S SIGNATURE OR NAME <u>Clara Fortune</u>		ADDRESS <u>1618 N 19th</u>				
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>acute dilatation aortic left ventricle</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Uremia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> <u>4 mo.</u>	
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 checked="" 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.) <u>5/11/50</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
21f. HOW DID INJURY OCCUR? <u>H.370</u>		22. I hereby certify that I attended the deceased from <u>June 5, 1949</u> , to <u>May 11, 1950</u> , that I last saw the deceased alive on <u>May 11, 1950</u> , and that death occurred at <u>2:45 p.m.</u> , from the causes and on the date stated above.				
23a. SIGNATURE <u>A. Ciapreick M.D.</u>		(Degree or title)		23b. ADDRESS <u>1901 Maduin St.</u>		
23c. DATE SIGNED <u>5/12/50.</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5/15/50</u>		
24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Genevieve Mo</u>		DATE REC'D BY LOCAL REG. <u>MAY 4 1950</u>		
REGISTRAR'S SIGNATURE <u>J. Casater</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Central Home 5541 River View Ave</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

Tom

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 _____

James Bunkley
Licensed Embalmer No. 365

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.