

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2794**
Registrar's No. **0109**

FILED JAN 26 1952
BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (In this place) 8 days		d. FULL NAME OF HOSPITAL OR INSTITUTION Bethesda Hospital	
d. STREET ADDRESS 910 Julia Avenue			
3. NAME OF DECEASED (Type or Print) a. (First) Nola b. (Middle) c. (Last) Fogilphol		4. DATE OF DEATH (Month) (Day) (Year) January 4, 1952	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH Mar. 12, 1893
9. AGE (In years last birthday) 58		IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Poplar Bluff, Missouri
12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME Jim Gunn		13b. MOTHER'S MAIDEN NAME Clara Davis	14. NAME OF HUSBAND OR WIFE Leo
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Leo Fogilphol
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		17. ADDRESS 910 Julia Avenue	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Malignant Hypertension		2 years	
DUE TO (c)			
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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 331X	
22. I hereby certify that I attended the deceased from January 1951 , to 1-4, 1952 , that I last saw the deceased alive on 1-4, 1952 , and that death occurred at 2:35 P.m. , from the causes and on the date stated above.			
23a. SIGNATURE Anita Younger <i>Anita Younger, M.D.</i> (Degree or title)		23b. ADDRESS 3624 Russell	23c. DATE SIGNED 1-5-52
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1-8-52	24c. NAME OF CEMETERY OR CREMATORY Mount Hope	24d. LOCATION (City, town, or county) (State) Lemay Missouri
DATE REC'D BY LOCAL REG. JAN 6 1952	REGISTRAR'S SIGNATURE <i>J. Earl Smith M.C.</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McLaughlin 2301 Lafayette Avenue	

Dr. Anita Younger, MD
36 24 Russell Blvd.
5:00 P.M. Sat. 1/5/

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 _____

L. R. Cooper

Licensed Embalmer No. *3623*

P. O. Address *2317 Lafayette*

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.