

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21992**
Registrar's No. **5087**

FILED JUN 27 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2179	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mt. Pacific Hosp.		17 3619 Shenandoah Ave.	

3. NAME OF DECEASED (Type or Print)	a. (First) CHARLES	b. (Middle) EARL	c. (Last) FORTUNE	4. DATE OF DEATH (Month) (Day) (Year)
				June 2 1952

5. SEX M.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M.	8. DATE OF BIRTH Sept. 3, 1885	9. AGE (In years last birthday) 66	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Hours	12. IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Expressman	10b. KIND OF BUSINESS OR INDUSTRY R.R. Express	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME P.G. Fortune	13b. MOTHER'S MAIDEN NAME Alice Palmer	14. NAME OF HUSBAND OR WIFE Dorthea Fortune
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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) No	16. SOCIAL SECURITY NO. 714-05-5923	17. INFORMANT'S SIGNATURE OR NAME Dorthea Fortune	ADDRESS 3619 Shenandoah
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 12 hours
	ANTECEDENT CAUSES DUE TO (b) Symptomatic Purpura		3 weeks
	DUE TO (c) leukemia, myelogenous, acute		5 months
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"/>
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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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 2041
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22. I hereby certify that I attended the deceased from **JAN 2, 1952**, to **JUNE 2, 1952**, that I last saw the deceased alive on **JUNE 2, 1952**, and that death occurred at **9:15 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Clarence Sullivan MD (Degree or title)	23b. ADDRESS Mt. Pac. Hosp.	23c. DATE SIGNED 6-2-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE June 4, 1952	24c. NAME OF CEMETERY OR CREMATORY Lawson Cemetery	24d. LOCATION (City, town, or county) (State) Lawson Mo.
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JUN 3 1952	25. FUNERAL DIRECTOR'S SIGNATURE McLaughlin Home ADDRESS 2301 Lafayette
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WRITE PLAINLY—USING UNFAADING 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. F. Harris*

Licensed Embalmer No. *3384*

P. O. Address *2301 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.