

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25786  
State File No. ....  
6892  
Registrar's No. ....

FILED JUL 31 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)						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS, MO. 0</u>			c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Stonefort</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>			d. STREET ADDRESS (If rural, give location)						
3. NAME OF DECEASED (Type or Print)			a. (First)		b. (Middle)				
<u>CECIL</u>			<u>HARRISON</u>		<u>FOX</u>				
5. SEX <u>Male 0</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED: NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widower 2</u>		8. DATE OF BIRTH <u>July 3, 1906</u>			
9. AGE (In years last birthday) <u>46</u>		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 1 HRS. Hours   Min. <u>7 15 52</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Miner</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Mining</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Illinois /</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13a. FATHER'S NAME <u>Lester Fox</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Estelle</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>357-01-4127</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Virgine Davis, Carrier Mills, Ill.</u>			ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CHRONIC LYMPHOCYTIC LEUKEMIA</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs.</u>		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			ANTECEDENT CAUSES				DUE TO (b) _____		
			Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last:				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)			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>2040.</u>				
22. I hereby certify that I attended the deceased from <u>JULY 5, 1952</u> , to <u>JULY 15, 1952</u> , that I last saw the deceased alive on <u>JULY 15, 1952</u> , and that death occurred at <u>12:30pm.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>F.P. Madley</u> (Degree or title) <u>M.D. 0</u>				23b. ADDRESS <u>BARNES HOSPITAL</u>			23c. DATE SIGNED <u>7/15/52</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal 5</u>		24b. DATE <u>7-15-52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Crab Orchard, Ill.</u>		24d. LOCATION (City, town, or county) (State)			
DATE REC'D BY LOCAL REG. <u>JUL 16 1952</u>			REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe, 4700 Washington Blvd.</u>			ADDRESS	

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 *John S. Renneke* .....

Licensed Embalmer No. *4199* .....

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.