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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 2 1952

40172
State File No. 10059
Registrar's No.

BIRTH NO. 79559 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 town) ST Louis		c. CITY (If outside corporate limits, write RURAL and give township) ST Louis 2119	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 11 2705 A BACON ST	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST LUKES HOSPITAL			
3. NAME OF DECEASED (Type or Print) a. (First) Jibh		b. (Middle)	
c. (Last) FAUR		4. DATE OF DEATH (Month) (Day) (Year) 10-31-52	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 10-17-52
9. AGE (In years last birthday) 14		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	
11. BIRTHPLACE (State or foreign country) ST Louis, MO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10b. KIND OF BUSINESS OR INDUSTRY NONE		13a. FATHER'S NAME CARL FAUR	
13b. MOTHER'S MAIDEN NAME ALTA McCURRY		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT'S SIGNATURE OR NAME CARL FAUR		ADDRESS 2705# BACON ST	

18. NOSE 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia		ANTECEDENT CAUSES		3 days	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Premature				LIFE	
DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS			
		Conditions contributing to the death but not related to the disease or condition causing death. Hypoglycemia		5 days	
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 7635	

22. I hereby certify that I attended the deceased from 10/24, 1952, to 11/31, 1952, that I last saw the deceased alive on 11/31, 1952, and that death occurred at 1:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE H.E. Wächter M.D.		(Degree or title)		23b. ADDRESS Brannont Bldg	
23c. DATE SIGNED 11-1-52		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 11-3-52	
24c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK		24d. LOCATION (City, town, or county) ST Louis County		(State) MO	
DATE REC'D BY LOCAL REG. NOV 1 1952		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE A. Brown & U. Co. 2707 N. Grand	

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 _____

working under my personal supervision.

Student Embalmer No.....

Not Embalmed.

Signed _____

Signed.....
Student Embalmer

Licensed Embalmer No.....

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.