

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

40211

State File No. ....

10643

Registrar's No. ....

No. 300  
10-48

FILED DEC 12 1952

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. ....		Registrar's No. ....		
<b>1. PLACE OF DEATH</b> a. COUNTY _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>			c. LENGTH OF STAY (In this place) <u>8 weeks</u>			c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>			<u>2039</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Park Lane Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>3 7130 Sutherland Ave.</u>						
<b>3. NAME OF DECEASED</b> (Type or Print)		a. (First) <u>Grace</u>		b. (Middle) <u>Pauline</u>		c. (Last) <u>Fuller</u>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Nov. 17. 1952</u>		
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>Married</u>		<b>8. DATE OF BIRTH</b> <u>June 6, 1903</u>		<b>9. AGE</b> (In years last birthday) <u>49</u>	<b># UNDER 1 YEAR</b> Months _____ Days _____	<b># UNDER 24 HRS.</b> Hours _____ Mins _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own home</u>		<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <u>Hickory, Ky.</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13a. FATHER'S NAME</b> <u>Josh Drew</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Gussie Parrish</u>			<b>14. NAME OF HUSBAND OR WIFE</b> <u>Arnie Fuller</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>No</u>		<b>17. INFORMANT'S SIGNATURE OR NAME</b> ADDRESS <u>Arnie Fuller, 7130 Sutherland Ave.</u>						
<b>18. CAUSE OF DEATH</b> 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.		<b>MEDICAL CERTIFICATION</b> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <u>Cerebrum Right Lung</u>  <b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. ---  <b>DUE TO (b)</b> _____  <b>DUE TO (c)</b> _____						<b>INTERVAL BETWEEN ONSET AND DEATH</b>		
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.		<b>19a. DATE OF OPERATION</b>						<b>19b. MAJOR FINDINGS OF OPERATION</b>		
<b>19a. DATE OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21c. (CITY, TOWN, OR TOWNSHIP)</b> (COUNTY) (STATE)						
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> <u>1163x</u>						
<b>22. I hereby certify that I attended the deceased from <u>8-30</u>, 19<u>52</u>, to <u>11-17</u>, 19<u>52</u>, that I last saw the deceased alive on <u>11-17</u>, 19<u>52</u>, and that death occurred at <u>10:15P</u> m., from the causes and on the date stated above.</b>										
<b>23a. SIGNATURE</b> (Degree or title) <u>PB Cappel md</u>				<b>23b. ADDRESS</b> <u>3284 Franklin Ave</u>			<b>23c. DATE SIGNED</b> <u>11-19-52</u>			
<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u>		<b>24b. DATE</b> <u>Nov. 19, 1952</u>		<b>24c. NAME OF CEMETERY OR CREMATORY</b> <u>Trinity Cemetery</u>		<b>24d. LOCATION</b> (City, town, or county) (State) <u>Mayfield, Ky.</u>				
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. Earl Smith, M.D.</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>C. Hoffmeister Colonial Mortuary</u> <u>646 Chippewa St., St. Louis, Mo.</u>								

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

~~XXXXXXXXXXXXXXXXXXXX~~

Dr. Dr. P. B. Cappel  
3284 Ivanhoe Ave.,  
HI 2502

10. 16 12:00 AM

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 Lesius C. Hoffmann

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broadway

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.