

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6149**

FILED MAR 8 1954

REG. DIST. NO. **318**PRIMARY REG. DIST. NO. **1003**Registrar's No. **1824**

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, MISSOURI		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL		e. STREET ADDRESS (If rural, give location) 10 4244 GANO AVE 2109		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) SAM		b. (Middle)		c. (Last) FAIRWEISER	
4. DATE OF DEATH (Month) (Day) (Year) FEBRUARY 24, 1954		5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH MAY 1-1881		9. AGE (In years last birthday) 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELEVATOR OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) MANCHESTER, MO	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME HY FAIRWEISER		13b. MOTHER'S MAIDEN NAME OK	
14. NAME OF HUSBAND OR WIFE MARGARET FAIRWEISER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) N/O		16. SOCIAL SECURITY NO. 489-03-0620	
17. INFORMANT'S SIGNATURE OR NAME MILDRED ANDERSON		ADDRESS 4244 GANO		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.	
19. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 177X	
22. I hereby certify that I attended the deceased from 1-25-54 , 19___, to 2-24-54 , 19___, that I last saw the deceased alive on 2-24-54 , 19___, and that death occurred at 2:20P m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Phillip Camens MD		23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 2-25-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 2-27-54		24c. NAME OF CEMETERY OR CREMATORY CALVARY	
24d. LOCATION (City, town, or county) (State) ST. LOUIS MO		DATE REC'D BY LOCAL REG. FEB 25 1954		REGISTRAR'S SIGNATURE J. Carl Smith M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE M.W.A. STOCK		ADDRESS 2117 E GRAND			

(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed *Elton Vremlina*.....

Licensed Embalmer No. *47*.....

P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.