

THE DIVISION OF HEALTH OF MISSOURI

11389-54 STANDARD CERTIFICATE OF DEATH

6163

State File No. 1491

FILED MAR 4 1954

318

1003

BIRTH NO. REG. DIST. NO. PRIMARY REG. DIST. NO. REGISTRAR'S NO.

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

d. FULL NAME OF HOSPITAL OR INSTITUTION Evangelical Deaconess

d. STREET ADDRESS (If rural, give location) 14 5830a Tholozan 2149

3. NAME OF DECEASED (Type or Print)
a. (First) (Unnamed) Twin B b. (Middle) c. (Last) Fessler

4. DATE OF DEATH (Month) (Day) (Year) 1-28-54

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant

8. DATE OF BIRTH January 28, 1954

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 1 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Walter Edward Fessler

13b. MOTHER'S MAIDEN NAME Gloria Dorothy Fricke

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT'S SIGNATURE OR NAME ADDRESS 5830a Tholozan Mrs. Walter Fessler

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, ashenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity 19 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Maternal. Severe respiratory infection 6th week

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES NO

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) m.

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? 774X

22. I hereby certify that I attended the deceased from Jan 28, 1954, to Jan 28, 1954, that I last saw the deceased alive on Jan 28, 1954, and that death occurred at 10:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Francis D. Weibel M.D.

23b. ADDRESS 5203 Cheppings St.

23c. DATE SIGNED Jan 29 1954

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE 2-27-54

24c. NAME OF CEMETERY OR CREMATORY Anatomical Board

24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE FER 19 1954 J. Carl Smith M.D.

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland-Aker Mortuary Service 4124 Manchester Ave. St. Louis 10, Mo.

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 _____

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.