

FILED JUN 10 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **16614**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4610**

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY      |  |
| b. CITY (If outside corporate limits, write RURAL and give town or township) <b>St. Louis</b> |  | c. CITY OR TOWN <b>St. Louis</b>  |  |
| c. LENGTH OF STAY (in this place) <b>9 Days</b>   |  | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mo. Baptist Hosp.</b>                              |  | STREET ADDRESS (If rural, give location) <b>222 2022a Hickory</b>   |  |

|                                     |                       |             |                         |   |
|-------------------------------------|-----------------------|-------------|-------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <b>ADA</b> | b. (Middle) | c. (Last) <b>FETZER</b> | 4. DATE OF DEATH (Month) (Day) (Year) <b>May 25, 1955</b> |
|-------------------------------------|-----------------------|-------------|-------------------------|---|

|                      |                               |   |                                      |   |                             |                             |
|----------------------|-------------------------------|---|--------------------------------------|---|-----------------------------|-----------------------------|
| 5. SEX <b>Female</b> | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b> | 8. DATE OF BIRTH <b>Mar. 2, 1895</b> | 9. AGE (In years last birthday) <b>60</b> | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
|----------------------|-------------------------------|---|--------------------------------------|---|-----------------------------|-----------------------------|

|  |   |  |   |
|--|---|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> | 10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b> | 11. BIRTHPLACE (City and State or Foreign Country) <b>Dexter, Mo</b> | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b> |
|--|---|--|---|

|                                     |  |  |
|-------------------------------------|--|--|
| 13a. FATHER'S NAME <b>Lee Adams</b> | 13b. MOTHER'S MAIDEN NAME <b>Mollie Malone</b> | 14. NAME OF HUSBAND OR WIFE <b>Joseph Fetzer</b> |
|-------------------------------------|--|--|

|  |                                   |  |         |
|--|-----------------------------------|--|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b> | 16. SOCIAL SECURITY NO. <b>No</b> | 17. INFORMANT'S SIGNATURE OR NAME <b>Joseph Fetzer, 2022a Hickory, St.L.</b> | ADDRESS |
|--|-----------------------------------|--|---------|

|   |   |                 |                                  |
|---|---|-----------------|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION   |                 | INTERVAL BETWEEN ONSET AND DEATH |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Vascular Hemorrhage</b>  |                 | <b>1 day</b>                     |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Hypertensive Cardiovascular Disease?</b><br>DUE TO (c) <b>hepatitis, chronic</b> |                 | <b>? years</b><br><b>? years</b> |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>Diabetes Mellitus</b>  |   | <b>10 years</b> |                                  |

|                        |                                  |  |
|------------------------|----------------------------------|--|
| 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) m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <b>592X</b> |
|--|--|--|

22. I hereby certify that I attended the deceased from **4/12**, 19**55**, to **5/25**, 19**55**, that I last saw the deceased alive on **5/24**, 19**55**, and that death occurred at **12:35** a.m., from the causes and on the date stated above.

|  |   |                                 |
|--|---|---------------------------------|
| 23a. SIGNATURE (Degree or title) <b>Jason Burbanck, M.D.</b> | 23b. ADDRESS <b>457 N. Kuegel Highway</b> | 23c. DATE SIGNED <b>5/26/55</b> |
|--|---|---------------------------------|

|  |           |  |  |
|--|-----------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b> | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b> | 24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b> |
|--|-----------|--|--|

|   |  |   |  |
|---|--|---|--|
| DATE REC'D BY LOCAL REG. <b>MAY 26 1955</b> | REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b> | 25. FUNERAL DIRECTOR'S SIGNATURE <b>McLaughlin F.H., Inc.</b> | ADDRESS <b>2301 Lafayette St. Louis, Mo.</b> |
|---|--|---|--|

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

Dr. BIRENBAUM.  
JEWISH HOSPITAL  
DR. OFFICE - EMERGENCY ROOM  
8:30 AM, THURSDAY

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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..... *James R. Chapman*

Licensed Embalmer No. .... *40*

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.