

FILED DEC 5 1955

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38218**
Registrar's No. **10262**

BIRTH NO. _____ 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)	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		a. STATE Missouri	b. COUNTY St. Louis
c. LENGTH OF STAY (In this place)		c. CITY OR TOWN Clayton	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 St. John's Hospital		e. STREET ADDRESS (If rural, give location) 6314 South Rosebury	H051

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) Joseph	b. (Middle)	c. (Last) Fadenhecht	November 24, 1955		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 26, 1883	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Retail Grocery	11. BIRTHPLACE (City and State or Foreign Country) Austria		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Jacob Fadenhecht	13b. MOTHER'S MAIDEN NAME Amelia Shapiro	14. NAME OF HUSBAND OR WIFE Fannie
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Fannie Fadenhecht ADDRESS 6314 S. Rosebury

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 1 day
	ANTECEDENT CAUSES Coronary Thrombosis		
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 420-1	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?

22. I hereby certify that I attended the deceased from **11-23**, to **11-24**, 19**55**, that I last saw the deceased alive on **11-24**, 19**55**, and that death occurred at **7:30 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Carl R. Smith M.D. (Degree or title)	23b. ADDRESS 11 S. King Highway	23c. DATE SIGNED 11-24-55
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24a. BURIAL, CREMATION, REMOVAL Removal	24b. DATE 11/25/1955	24c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth	24d. LOCATION (City, town, or county) (State) University City, Mo.
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DATE REC'D BY LOCAL REG. NOV 25 1955	REGISTRAR'S SIGNATURE Carl R. Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Berger Memorial ADDRESS 4715 McPherson Ave.
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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 *Quinn J. Quindley*.....

Licensed Embalmer No. *4222*

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