

FILED MAR 7 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6441**  
Registrar's No. **1499**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>MO</b><br>b. COUNTY <b>St. Louis</b>                      |  |
| b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <b>St Louis</b> |  | c. CITY OR TOWN <b>Webster Groves</b><br>d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>                          |  | e. STREET ADDRESS (If rural, give location) <b>959 Sanders Dr</b>   |  |

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|---|--|---|---|--|--|
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <b>Clarence</b> b. (Middle) <b>W</b> c. (Last) <b>Fetsch</b> |  |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>2 10 56</b> |  |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b>                       |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>  |  |
| 8. DATE OF BIRTH <b>11-26-01</b>  |  | 9. AGE (In years last birthday) <b>54</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>Dispatcher</b>     |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Yellow Cab</b> |   | 11. BIRTHPLACE (City and State or Foreign Country) <b>St Peters Mo</b> |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>   |  |   |   |  |  |

|                                       |  |  |  |   |  |
|---------------------------------------|--|--|--|---|--|
| 13a. FATHER'S NAME <b>John Fetsch</b> |  | 13b. MOTHER'S MAIDEN NAME <b>Margaret Roeper</b> |  | 14. NAME OF HUSBAND OR WIFE <b>Elsie Fetsch</b> |  |
|---------------------------------------|--|--|--|---|--|

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) |  | 16. SOCIAL SECURITY NO. <b>488-10-1860</b> |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs Elsie Fetsch 959 Sanders Dr</b> |  |
|--|--|--|--|--|--|

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| 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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusion</b><br>ANTECEDENT CAUSES <b>Cardio Vascular disease</b><br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c)<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  | INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b> |  |
|---|--|--|--|---|--|

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|---|--|--|--|--|--|
| 19a. DATE OF OPERATION                          |  | 19b. MAJOR FINDINGS OF OPERATION <b>✓</b>  |  | 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 **July 1954** to **2/10 1956** that I last saw the deceased alive on **2/10 1956**, and that death occurred at **6 p. m.**, from the causes and on the date stated above.

|   |  |                                   |  |                                 |  |
|---|--|-----------------------------------|--|---------------------------------|--|
| 23a. SIGNATURE <b>James J. Pyle, M.D.</b> (Degree or title) |  | 23b. ADDRESS <b>730 Hodiamont</b> |  | 23c. DATE SIGNED <b>2-11-56</b> |  |
|---|--|-----------------------------------|--|---------------------------------|--|

|   |  |                          |  |   |  |
|---|--|--------------------------|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>           |  | 24b. DATE <b>2-13-56</b> |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b> |  |
| 24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo</b> |  |                          |  |   |  |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| DATE REC'D BY LOCAL REG. <b>FEB 14 1956</b> |  | REGISTRAR'S SIGNATURE <b>J. Carl Smith</b> |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Jos W Clark Funeral Home Inc - 1125 Hodiamont Ave</b> |  |
|---|--|--|--|---|--|

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNEADING 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 *John S. Renne*.....  
Licensed Embalmer No. *419*.....  
P. O. Address *St. Lou.*.....

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.