

FILED NOV 15 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37439

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registration No. **10238**

Health, Welfare & Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hosp.		Length of stay in 1b		STREET ADDRESS 4456 Virginia Ave. (If outside, give location)	
3. NAME OF DECEASED (Type or print) First Middle Last Stephanie Foxworth			4. DATE OF DEATH Month Day Year Oct. 30 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> newer married WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28, 1957	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Day Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Louis, Mo.	
13. FATHER'S NAME William Foxworth			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
14. MOTHER'S MAIDEN NAME Nancy Drapp			17. INFORMANT Address William Foxworth 4456 Virginia Ave.		
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. No		17. INFORMANT Address William Foxworth 4456 Virginia Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Encephalomyelose (anomaly at birth)</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
INTERVAL BETWEEN ONSET AND DEATH					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2					
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 10-28-57 to 10-30-57 and last saw her alive on 10-30-57 Death occurred at 5:00 P m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>William Paul Dudge</i>				22b. ADDRESS <i>16 Wagonwheel Valley Plaza</i>	
22c. DATE SIGNED OCT 31 '57					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Oct. 31, 1957		SS Peter & Paul Cemetery	
24. FUNERAL DIRECTOR Homeister Colonial Mortuary 6464 Chippewa St., St. Louis, Mo.		25. DATE RECD. BY LOCAL REG. OCT 31 '57		26. REGISTRAR'S SIGNATURE <i>Carl Smith</i>	

(Licensed Embalmer's Statement on Reverse Side)

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.....

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