

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016048

STATE FILE NUMBER

FILED APR 27 1959

Registration District No. 317

Primary Registration District No. 341

Registrar's No. 1081

1. PLACE OF DEATH a. COUNTY St. Louis.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri. b. COUNTY St. Louis.	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton, Mo.		c. CITY OR TOWN Olivette 4380	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis County Hospital		d. STREET ADDRESS (If outside, give location) 15 Heather Hill Lane	
3. NAME OF DECEASED (Type or print) First Edgar Middle Allen Last Fay		4. DATE OF DEATH Month 4 Day 18 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Sr. Equip. Engr. Southwestern Bell Tel. Co. Chicago, Illinois.		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) U.S.A.
13a. FATHER'S NAME Marshall Fay		13b. MOTHER'S MAIDEN NAME Irinda Stafford	14. NAME OF HUSBAND OR WIFE Ethelyn
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. Nil.		16. SOCIAL SECURITY NO. 488-10-4342	17. INFORMANT Address Mrs. Ethelyn Fay, 15 Heather Hill Lane
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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 3/31/59 4/18/59
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. _____		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 12/1/58 P. to 3/31/59 and last saw him alive on 3/31/59 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Angelo A. Speno M.D.		22b. ADDRESS 601 So Brentwood	
22c. DATE SIGNED 4/20/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 4-20-59	
23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory		23d. LOCATION (City, town, or county) St. Louis County, Mo.	
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe 4700 Washington, Blvd.		25. DATE RECD. BY LOCAL REG. 4-20-59 26. REGISTRAR'S SIGNATURE John C. Murphy, M.D.	

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate ^{not} ~~is~~ embalmed
by me, or by Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Was not Embalmed.

Signed J. W. Wilkinson

Licensed Embalmer No. 357
P. O. Address M. 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.