

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

59-038476

FILED VS OCT 19 1959

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2685

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>St. Louis</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Florissant</u>		a. STATE <u>Mo.</u>		b. COUNTY <u>St. Louis</u>	
Length of stay in 1b <u>1 Month</u>		c. CITY OR TOWN <u>Florissant</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1690 Gallant Fox Dr.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1690 Gallant Fox Dr.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. SEX	
First <u>HERMAN</u> Middle <u>L.</u> Last <u>FETZNER</u>			Month <u>Oct.</u> Day <u>8</u> Year <u>1959</u>			Male	
6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 27, 1886</u>		9. AGE (last birthday) <u>72</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer (Retired) Woodward &amp; Tiernan Prtg. Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Iron Mountain, Mo.</u>		11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <u>Unknown Fetzner</u>			13b. MOTHER'S MAIDEN NAME <u>Louise Oberley</u>			14. NAME OF HUSBAND OR WIFE <u>Late Florence Fetzner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>488-10-3753</u>		17. INFORMANT Address <u>Dolores Bohne 1690 Gallant Fox Dr.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u>						<u>12 years</u>	
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)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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 <u>5:45</u> a.m. <u>P.</u> Month, Day, Year <u>May 11, 1959</u>		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 <u>May 11, 1959</u> to <u>Oct. 8, 1959</u> and last saw her alive on <u>10-8-59</u> Death occurred at <u>5:45 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>O. Wourmes M.D.</u>			22b. ADDRESS <u>3720 Washington Blvd.</u>			22c. DATE SIGNED <u>10-9-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Oct. 12, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Churchyard</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Kriegshauser 4228 S. Kingshighway</u>			25. DATE RECD. BY LOCAL REG. <u>10-9-59</u>		26. REGISTRAR'S SIGNATURE <u>J. B. Wurfley M.D.</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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

*Erin A Mc Dermott*

Licensed Embalmer No. 3024

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.