

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041802

FILED VS DEC 7 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **210974**

ENDED

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		Length of stay in 1b 5 days		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Park Lane Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1907 E. Linton Avenue			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Albert Middle Fague Last Fague				4. DATE OF DEATH Month Nov. Day 26 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 8-22-1884	9. AGE (last birthday) 75	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationery Fireman			10b. KIND OF BUSINESS OR INDUSTRY John Deere Company		11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME (Retired) George Fague			13b. MOTHER'S MAIDEN NAME Elizabeth Jung			14. NAME OF HUSBAND OR WIFE Lillian Fague				
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. 489-10-9989		17. INFORMANT Address Mrs. Lillian Fague, 1907 E. Linton Av					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Euphoric Accident 4-27-59 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Diarrhea, nephritis and Chronic DUE TO (c) Pulmonary Edema 24 hrs								INTERVAL BETWEEN ONSET AND DEATH		
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 _____ a.m. _____ p.m. Month, Day, Year _____										
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 Aug 59 to 11-26-59 and last saw ^{her} him alive on 11-23-59 Death occurred at 4 PM 11/26/59 m on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) W. A. Kuyper				22b. ADDRESS 6701 N. Broad Street				22c. DATE SIGNED 11/27/59		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Nov 30 1959	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery			23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri				
24. FUNERAL DIRECTOR ADDRESS Math Hermann & Son, Inc., 2161 E. Fair Av			25. DATE RECD. BY LOCAL REG. NOV 27 1959		26. REGISTRAR'S SIGNATURE Loal Smith, M.D. <i>mbs</i>					

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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Allen H. Vez

Licensed Embalmer No. 3737

P. O. Address S. J. Logan, N.

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.