

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-012566

FILED VS MAR 3 1 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 3295** STATE FILE NUMBER

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		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony' Hospital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1445 St. Louis Av.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle FABLE Last				4. DATE OF DEATH Mar. 20-60 Month Day Year				
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 4/15/1898	9. AGE (last birthday) 61	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) Retired			10b. KIND OF BUSINESS OR INDUSTRY Western Union		11. BIRTHPLACE (City and state or country) Cross Town, Mo.,		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME William Fable			13b. MOTHER'S MAIDEN NAME Alice Hager			14. NAME OF HUSBAND OR WIFE Maud Fable		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, not or unknown) (If yes, give war or dates of service) Unknown			16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Maud Fable 1445 St. Louis 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) Cardio Vascular Heart Disease DUE TO (b) Posterior Infarctus DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH July 1955 3	
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 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 July 1-1956 to March 20-1960 and last saw him live on March 20-1960 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE H. J. Moore M.D. (Degree or title)				22b. ADDRESS 917-5018			22c. DATE SIGNED 3-22-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Mar. 23/1960	23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cem.		23d. LOCATION (City, town, or county) (State) St. Louis County Mo.,			
24. FUNERAL DIRECTOR ADDRESS Leidner Undertaking Co., 2223 St. Louis.				25. DATE RECD. BY LOCAL REG. MAR 22 1960		26. REGISTRAR'S SIGNATURE Loard Smith, M.D.		

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 Albert Mayfield

Licensed Embalmer No. 3077

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.