URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

EILED VS, SEP 7 1960

-60-033316

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2531

1. PLACE OF DEATH
a. COUNTY Saint Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Normandy
Length of stay in 1b: 13 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Normandy Osteopathic Hosp. Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY ST LOUIS
c. CITY OR TOWN Glendale Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 15 Berrywood Dr. Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First: Ethel Middle: Last: Fabre
4. DATE OF DEATH Month: Aug. Day: 24, Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 6-18-1890
9. AGE (last birthday): 70
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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: U S A
13a. FATHER'S NAME: unk
13b. MOTHER'S MAIDEN NAME: unk
14. NAME OF HUSBAND OR WIFE: Fred Fabre
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Medical Record Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Medullary failure
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral anoxia
DUE TO (c) Cerebral ischemia + infarction — INTERVAL BETWEEN ONSET AND DEATH: 14 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Cerebral atherosclerosis
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☑ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 6-11-60, to 8-24-60 and last saw her/him alive on 8-24-60
Death occurred at 6:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE H. C. Gardner (Degree or title) M.D.
22b. ADDRESS 917 Dunport Rd. Ferguson
22c. DATE SIGNED 8-24-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE: 8-26-1960
23c. NAME OF CEMETERY OR CREMATORY: Mo. Crematory
23d. LOCATION (City, town, or county) (State): St. Louis Mo.
24. FUNERAL DIRECTOR: Parker-Aldrich Webster Groves Mo. ADDRESS
25. DATE RECD. BY LOCAL REG.: 8-25-60
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

DEC 8 1961

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_____ Signed Leslie Welch

Signature of Student Embalmer

Licensed Embalmer No. 439

P. O. Address Webster

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