

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-003070

XC 120 6615

FILED VS. JAN 25 1961 SL 6104

AMENDED Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **417** STATE FILE NUMBER

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>St. Louis</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST LOUIS, MISSOURI</b>		Length of stay in 1b <b>134 DAYS</b>		c. CITY OR TOWN <b>ST LOUIS HILLSDALE</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADMIN HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>2155 Crescent Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>LAWRENCE</b> Middle <b>P.</b> Last <b>FIEBIG</b>				4. DATE OF DEATH Month <b>1</b> Day <b>12</b> Year <b>61</b>									
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>10-14-96</b>		9. AGE (last birthday) <b>64</b>		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) <b>TAVERN OWNER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>TAVERN</b>		11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>					
13a. FATHER'S NAME <b>CHARLES FIEBIG</b>				13b. MOTHER'S MAIDEN NAME <b>ANNA CLARNER</b>				14. NAME OF HUSBAND OR WIFE <b>CATHRINE FIEBIG</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW1</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>CATHRINE FIEBIG 2155 Crescent St. Louis Mo</b>							
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) <b>PNEUMONIA WITH ABSCESS FORMATION, BILATERAL</b>													
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>RETICULUM CELL SARCOMA-INVOLVING NODES, HEART, PANCREAS, TESTIS, PROSTATE.</b>											
		DUE TO (c) <b>2021</b>											
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 checked="" type="checkbox"/> NO <input 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. <input checked="" type="checkbox"/> attended the deceased from <b>VA 9-1-60</b> to <b>1-12-61</b> and last saw him alive on <b>1-12-61</b>		Death occurred at <b>7:45 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <b>ROBERT C. BURGER, M.D. VA HOSPITAL 915 NO. GRANDST. LOUIS, MO.</b>						22b. ADDRESS			22c. DATE SIGNED <b>1-12-61</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Jan 16, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Sst. Louis County, Missouri</b>							
24. FUNERAL DIRECTOR ADDRESS <b>Math Hermann &amp; Son, Inc., 2161 E. Fair Av St. Louis, 7, Missouri</b>				25. DATE RECD. BY LOCAL REG. <b>JAN 16 1961</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>							

**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 Clement McNeary

Licensed Embalmer No. 3732

P. O. Address A. L. Linn

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.