

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**-61-047170**

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3356

**FILED DEC 18 1961**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Creve Coeur</b>		c. CITY OR TOWN <b>Creve Coeur</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>12190 Lake Placid Ln.</b>		d. STREET ADDRESS (If outside, give location) <b>12190 Lake Placid Ln.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Sidney</b> Middle <b>Fox</b> Last <b>Fox</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>26,</b> Year <b>1961</b>		
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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>1/13/27</b>	9. AGE (last birthday) <b>34</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Men's Clothing</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Max Fox</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Stone</b>	14. NAME OF HUSBAND OR WIFE <b>Charlotte Fox</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unk.</b>	16. SOCIAL SECURITY NO. <b>Unk.</b>	17. INFORMANT <b>Mrs. S. Fox-12190 Lake Placid Ln.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unk</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. ) 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
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19. WAS AUTOPSY PERFORMED? YES <input 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.)
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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 _____
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at **2:15** p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Raymond Harold</i> (Degree or title) <b>Coroner</b>	22b. ADDRESS <b>Clayton, Mo.</b>	22c. DATE SIGNED <b>11/29/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/28/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chevra Kadisha Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
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24. FUNERAL DIRECTOR <b>Herman Rindskopf, Inc.</b>	ADDRESS <b>5216 Delmar</b>	25. DATE RECD. BY LOCAL REG. <b>11-27-61</b>	26. REGISTRAR'S SIGNATURE <i>J. B. Murphy</i>
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DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 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 Peter B. Dubouille

Licensed Embalmer No. 3691

P. O. Address St Louis Mo

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.