

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-025467

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1859

FILED JUL 2 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>                |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Richmond Heights</b>  |   | c. CITY OR TOWN<br><b>Richmond Heights</b>  |  |
| Length of stay in 1b<br><b>5 days</b>   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>   |   | d. STREET ADDRESS (If outside, give location)<br><b>4115 Southern Aire dr.</b>  |  |
| Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |   | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>KARL AUGUSTUS FOURNIER</b>  |   |   | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>21</b> Year <b>1962</b>   |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b>  | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6-16-62</b>   |
| 9. AGE (last birthday)<br><b>0</b>  |   | IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>5</b> Hours <b></b> Min. <b></b>   | IF UNDER 24 HR.<br>Hours <b></b> Min. <b></b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Richmond Heights</b>  | 11. BIRTHPLACE (City and state or country)<br><b>U. S. A.</b>  |
| 12. CITIZEN OF WHAT COUNTRY   |   | 13a. FATHER'S NAME<br><b>Edward Fournier</b>  |  |
| 13b. MOTHER'S MAIDEN NAME<br><b>Lois Elaine Prosser</b>   |   | 14. NAME OF HUSBAND OR WIFE   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO.   | 17. INFORMANT<br><b>Edward Fournier</b> Address <b>4115 Southern Aire Dr.</b>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Erythroblastosis fetalis</b>                                     |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m. _____ Month, Day, Year _____  |   |   |  |
| 20d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/><br>NOT WHILE AT WORK <input type="checkbox"/>  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>birth</b>  | 20f. CITY, TOWN, OR LOCATION<br><b>Crete</b>  | COUNTY _____ STATE _____   |
| 21. I attended the deceased from _____ to _____ and last saw her/him alive on _____<br>Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |
| 22a. SIGNATURE<br><i>Obitaries</i> (Degree or title)  |   | 22b. ADDRESS<br><b>16 Truman Village Plaza</b>  | 22c. DATE SIGNED<br><b>6/22/62</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>Jun. 22, 1962</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Resurrection Cemetery</b>  | 23d. LOCATION (City, town, or county)<br><b>St. Louis County, Missouri</b>   |
| 24. FUNERAL DIRECTOR<br><b>Gebken Sons</b> ADDRESS <b>2630 Gravois</b>  |   | 25. DATE RECD. BY LOCAL REG.<br><b>6-22-62</b>  | 26. REGISTRAR'S SIGNATURE<br><i>Joseph Murphy MD</i>   |

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.