

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-040199

STATE FILE NUMBER

Registration District No. **318** Primary Registration District **1003** Registrar's No. **9817**

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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24005, R3

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DATE AMENDED
10/22/62

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

Annette G.

SHOULD READ

Jeannette Sue Fleer

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO.

3

BY AFFIDAVIT OF Funeral Director

1. PLACE OF DEATH a. COUNTY St. Louis, Mo.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN Richmond Heights, Mo.	
Length of stay in lb		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		d. STREET ADDRESS (If outside, give location) 7067 Mitchell Ave. (17)	
3. NAME OF DECEASED (Type or print) First Jeannette Middle Sue Last Fleer		4. DATE OF DEATH Month 10 Day 11 Year 1962	
Baby Girl Annette G.			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-9-1962
9. AGE (last birthday) Infant		IF UNDER 1 YEAR IF UNDER 24 HR	
Months 1 Days 20 Hours 20 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		St. Louis, Mo.	
11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME Stanley Fleer		13b. MOTHER'S MAIDEN NAME Rosemary Walls	
14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
		17. INFORMANT Address Deaconess Hospital 6150 Oakland Ave.	
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) Hemorrhagic Pneumonia, Terminal			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Prematurity			
DUE TO (c) 763.5			
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. I attended the deceased from 10/9/62 to 10/11/62 and last saw her/him alive on 10/11/62		Death occurred at 545 A m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE W. S. Hawker, M.D. (Degree or title)		22b. ADDRESS #16 Hampton Village Plaza	
		22c. DATE SIGNED 10/11/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10/12/1962	23c. NAME OF CEMETERY OR CREMATORY St. Pauls Churchyard	
		23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri	
24. FUNERAL DIRECTOR ADDRESS BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave.		25. DATE RECD. BY LOCAL REG. OCT 12 1962	
		26. REGISTRAR'S SIGNATURE Loal Smith, D.V.	

8574

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.

Not Embalmed. D M Eichen

BEIDERWIEDEN FUNERAL HOME, Inc.

Student _____

Signed _____

Signature of Student Embalmer

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.

Vertical text on the right edge of the page, possibly a stamp or margin note, partially legible.