

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-044192

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10787**

FILED NOV 19 1962

VS 300
Rev. 4/59

1
2 *215*
3
4 *1*
5 *2*
6
7 *1*
8 *2*
9
10
11
12 *90-0*
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4261 Schiller Place			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4261 Schiller Place			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marie Middle R. Last Feager			4. DATE OF DEATH Month November Day 8 Year 1962						
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/20/1882	9. AGE (last birthday) 80	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and state or country) Fairway, Iowa		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME Franz Hug			13b. MOTHER'S MAIDEN NAME Christine Herman			14. NAME OF HUSBAND OR WIFE Fred			
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. None		17. INFORMANT Loretta Gamache		Address 4261 Schiller Place		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Rectum									INTERVAL BETWEEN ONSET AND DEATH 2 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 154X									
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 9-28-62 to 11-8-62 and last saw her alive on 11-7-62 Death occurred at 1:15 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE Eugene H. Edde M.D. (Degree or title)					22b. ADDRESS 4971 Chippewa St.		22c. DATE SIGNED 11-9-62		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 10, 1962		23c. NAME OF CEMETERY OR CREMATORY SS Peter & Paul Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri			
24. FUNERAL DIRECTOR C. Hoffmeister Mortuaries Address 5917 So. Broadway St. Louis, Mo.					25. DATE RECD. BY LOCAL REG. NOV 9 1962		REGISTRAR'S SIGNATURE Joan Smith. M.D.		

90

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 John L. Denney
Licensed Embalmer No. 4194
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.

Dr. Eugene Edale
4971 Chippewa

FL 2-3770

1283