

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044232

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **11855**

STATE FILE NUMBER

FILED DEC 14 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

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, MO.		Length of stay in 1b 2-mos. 10-days		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
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 type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3324a Winnebago		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sarah J. Fuhrer			4. DATE OF DEATH Month Day Year 12 8 1962			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 5/30/08		9. AGE (last birthday) 54		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) Lamp Exhauster		10b. KIND OF BUSINESS OR INDUSTRY N. Amer. Lamp Co.		11. BIRTHPLACE (City and state or country) California		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME Lemuel Fuhrer			13b. MOTHER'S MAIDEN NAME Bessie Reese			14. NAME OF HUSBAND OR WIFE none			
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 Bessie Fuhrer - 3324a Winnebago				
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cerebral Cortical Degeneration								INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) 334x									
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 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 9-18-62 to 12-8-62 and last saw her/him alive on 12-8-62 Death occurred at 7:55 A m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>John McDonough M.D.</i> (Degree or title)				22b. ADDRESS 1515 Lafayette			22c. DATE SIGNED 12-8-62		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Dec. 11, 1962		23c. NAME OF CEMETERY OR CREMATORY Bethany Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri			
24. FUNERAL DIRECTOR WACKER-HELDERLE-3634 Gravois Ave.				25. DATE RECD. BY LOCAL REG. DEC 11 1962		26. REGISTRAR'S SIGNATURE <i>Paul Smith, M.D.</i>			

MCDONOUGH
USE BLACK INK
OR
TYPEWRITER RIBBON

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 Delbert J. Krupin

Licensed Embalmer No. 3497

P. O. Address St. Louis

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.