

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-033635

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8282** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1  
2 **202**  
3  
4 **0**  
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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

**FILED AUG 22 1963**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>5705 Goethe Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>G.</b> Last <b>FOX</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>13</b> Year <b>1963</b>	
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>8-6-1890</b>
9. AGE (last birthday) <b>73</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Officer (Retired) Fox Bros. Planning Mill</b>	
11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>George Fox</b>		13b. MOTHER'S MAIDEN NAME <b>Catherine Krebs</b>	
14. NAME OF HUSBAND OR WIFE <b>Clara S. Fox</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no; or unknown) (If yes, give war or dates of) <b>Yes World War I</b>	
16. INFORMANT <b>Clara S. Fox 5705 Goethe Ave.</b>		17. ADDRESS	
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>BASILAR ARTERY THROMBOSIS</b> DUE TO (b) <b>CEREBRAL ARTERY ARTERIOSCLEROSIS</b> DUE TO (c) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease-condition given in PART I (a) <b>443X</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 HR'S</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.	
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 <b>JUNE 14, 1963</b> to <b>AUG. 13, 1963</b> and last saw him alive on <b>AUG. 13, 1963</b> Death occurred at <b>7:20 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Michael E. Cochran M.D.</b>		22b. ADDRESS <b>35 N. CENTRAL</b>	
22c. DATE SIGNED <b>8-17-63</b>		23. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine Cemetery</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Aug. 16, 1963</b>	
23c. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>		24. FUNERAL DIRECTOR: ADDRESS <b>Kriegshauser 4228 S. Kingshighway Blvd.</b>	
25. DATE RECD. BY LOCAL REG. <b>AUG 14, 1963</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>	

**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 James R. Munn

Licensed Embalmer No. 4527

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.