

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-034382

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2499

FILED AUG 19 1963

VS 300
Rev. 4/59

14000
24000 2

3

4 1

5 2

6

7 0

8 2

9 1992

10

11

12 90

13

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 St. Louis | | 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 Affton | | Length of stay in 1b 1 1/2 Yrs. | c. CITY OR TOWN Affton Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 7734 General Sheridan La. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 7734 General Sheridan La. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last ESTELLE K. FUGGER | | | 4. DATE OF DEATH Month Day Year Aug. 5 1963 |
| 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 7-7-1898 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor-Cocktail Lounge | | 10b. KIND OF BUSINESS OR INDUSTRY St. Louis, Mo. | 9. AGE (last birthday) 65 IF UNDER 1 YEAR IF UNDER 24 HR. Months Days Hours Min. |
| 11a. FATHER'S NAME William Klein | | 11b. MOTHER'S MAIDEN NAME Carrie Roth | 11c. NAME OF HUSBAND OR WIFE Late Herbert Fugger |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No None | | 16. SOCIAL SECURITY NO. A | 17. INFORMANT Address idan La. Mrs. LaVerne Hollowood 7734 General Sher- |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Natural causes, history of cancer con- dition for past 11 years | | | 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) _____ | | | |
| 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 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 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 _____ to _____ and last saw her alive on _____ Death occurred at 8:15 P. _____ m on the date stated above, and to the best of my knowledge, from the causes stated. DOA Co. Hosp. 10:50 P.M. | | | |
| 22a. SIGNATURE (Type or Print) <i>Raymond Harris</i> Coroner | | 22b. ADDRESS Clayton, Missouri | 22c. DATE SIGNED 8/13/63 |
| 23a. BURIAL, CREMATION, REMOVAL (Type or Print) Burial | 23b. DATE Aug. 8, 1963 | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery | 23d. LOCATION (City, town, or county) St. Louis Co. Mo. |
| 24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway Blvd. | | 25. DATE RECD. BY LOCAL REG. 8-6-63 | 26. REGISTRAR'S SIGNATURE <i>John B. Murphy M.D.</i> |

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

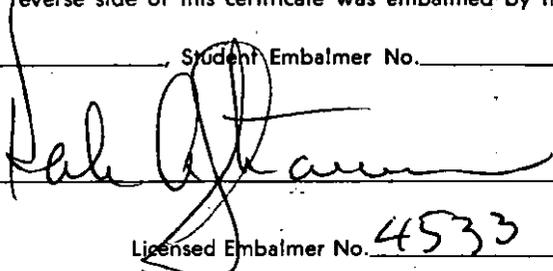
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 4533

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.