

FILED MAY 15 1944

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

Registrar's No. 4241

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: BARNES HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 22 days  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Macoupin  
(c) City or town Gillespie  
(If outside city or town limits, write "RURAL") NR  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 2

3. (a) PRINT FULL NAME Albert (Anna) Fuess

3. (b) If veteran, name war Unknown 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Laura Fuess 6. (c) Age of husband or wife if alive Unk. years

7. Birth date of deceased May 1 1876  
(Month) (Day) (Year)

8. AGE: Years 68 Months 0 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Gillespie Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name William Fuess  
13. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Elizabeth Schwartz  
15. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Louise Wheeler  
(b) Address Gillespie Illinois

17. (a) Removal (b) Date thereof 5-8-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Gillespie, Illinois

18. (a) Signature of funeral director Albert H. Hoppe  
(b) Address 4700 Washington Blvd.

19. (a) MAY 8 1944 J. F. Brudeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7  
year 1944 hour 11:30 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from April 15 1944 to May 7 1944  
that I last saw him alive on May 7 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of the prostate with metastases  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death) 51

Major findings: Of operations \_\_\_\_\_  
Of autopsy as above

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of plane) (e) Means of injury \_\_\_\_\_

23. Signature M. C. Abney (M. D. or other) \_\_\_\_\_  
Address BARNES HOSPITAL Date signed 5/8/44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *Albert G. Hopper* .....  
Licensed Embalmer No..... *2971* .....  
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 this body is not embalmed, fact should be so stated above.**