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.48

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

FILED APR 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13755

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3335

1. PLACE OF DEATH
a. COUNTY ~~St. Louis~~
b. CITY OR TOWN (If outside corporate limits, write RURAL and give (township)) St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Homer G Phillips Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
d. STREET ADDRESS (If rural, give location) 1103 North Channing Avenue

3. NAME OF DECEASED (Type or Print)
a. (First) Sylvester
b. (Middle)
c. (Last) Fox

4. DATE OF DEATH (Month) April (Day) 10, (Year) 1949

5. SEX male
6. COLOR OR RACE col
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH 4-12-1885
9. AGE (In years last birthday) 63 — If under 1 year: Months 11 Days 28 — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor
10b. KIND OF BUSINESS OR INDUSTRY Night Club
11. BIRTHPLACE (State or foreign country) Coffeesville Mississippi
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME John Fox
13b. MOTHER'S MAIDEN NAME
14. NAME OF HUSBAND OR WIFE Mary F. Fox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 499-01-4582
17. INFORMANT'S SIGNATURE OR NAME Mary F. Fox **ADDRESS** 1103 N. Channing Ave

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcinoma of Colon with Extensive Metastases — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Undet.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. None.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-8, *19*48, *to* 4-10, *19*49, *that I last saw the deceased alive on* 4-10, *19*49, *and that death occurred at* 7:15a *m., from the causes and on the date stated above.*

23a. SIGNATURE Charles R Frazer (Degree or title) M. D.
23b. ADDRESS 2601 N Whittier St
23c. DATE SIGNED 4-11-49

24a. BURIAL, CREMATION, REMOVAL (Specify)
24b. DATE 4-15-1949
24c. NAME OF CEMETERY OR CREMATORY Washington Park
24d. LOCATION (City, town, or county) St. Louis, Co. Mo (State)

DATE REC'D BY LOCAL REGISTRAR APR 14
REGISTRAR'S SIGNATURE J. B. Forster
25. FUNERAL DIRECTOR'S SIGNATURE J.H.Randle & Son **ADDRESS** 3133 Bell Avenue

(Licensed Embalmer's Statement on Reverse Side)

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 .....
Student Embalmer

Signed L. J. Watson

Licensed Embalmer No. 269A

P. O. Address 2769 Downtown

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.