

FILED DEC 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39734**

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 4443

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) Chesterfield		c. LENGTH OF STAY (In this place) 12 years	
d. FULL NAME OF HOSPITAL OR INSTITUTION Olive Street Road.		e. CITY (If outside corporate limits, write RURAL and give township) Chesterfield	
3. NAME OF DECEASED (Type or Print) a. (First) ANNETTE b. (Middle) KATHRYN c. (Last) FOX		4. DATE OF DEATH (Month) (Day) (Year) Nov 17, 1949	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 24, 1890
9. AGE (In years last birthday) 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME George A. Hoewel		13b. MOTHER'S MAIDEN NAME Minnie Jansing	
14. NAME OF HUSBAND OR WIFE Walter L. Fox		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. None		17. INFORMANT'S SIGNATURE OR NAME Walter L. Fox, Olive Street Road	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension (chronic) DUE TO (c) Nephritis. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 595X	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 2, 1942</u> , to <u>Nov 17, 1949</u> that I last saw the deceased alive on <u>Nov 16, 1949</u> , and that death occurred at <u>2:45 A.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Dr. Arnold H. Weizer M.D.		23b. ADDRESS 3115 Brunson Rd	
23c. DATE SIGNED 11/18/49		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE Nov 21, 1949		24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri		25. FUNERAL DIRECTOR'S SIGNATURE Shepard Funeral Home, 1167 Hamilton Ave	
DATE REC'D BY LOCAL REG Nov 18, 1949		REGISTRAR'S SIGNATURE Berbert R. Moulton M.D.	

(Licensed Embalmer's Statement on Reverse Side)

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

96

Mr. W. W. Wilkin
3115
2-4

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 Me

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Guy W. Wilkin

Licensed Embalmer No. 3575

P. O. Address St Louis Mo

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.