

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 14 1950

State File No. **24744**
Registrar's No. **6658**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3502 Pestalozzi St.		e. STREET ADDRESS (If rural, give location) 3502 Pestalozzi St.	

3. NAME OF DECEASED (Type or Print) DOROTHY M. FAGIN			4. DATE OF DEATH (Month) (Day) (Year) Aug. 2, 1950		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Jan. 29, 1913		9. AGE (In years last birthday) 37 # UNDER 1 YEAR Months 6 Days 3 # UNDER 1 Wk. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Harry D. Fagin	13b. MOTHER'S MAIDEN NAME Jennie Maloy	14. NAME OF HUSBAND OR WIFE _____
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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. _____	17. INFORMANT'S SIGNATURE OR NAME Harry D. Fagin-3502 Pestalozzi St.	ADDRESS 3502 Pestalozzi St.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Status Epilepticus		INTERVAL BETWEEN ONSET AND DEATH 3 hours 10 years
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Epilepsy Grandmull		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 253.1
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22. I hereby certify that I attended the deceased from **June**, 1942, to **July 2**, 1950, that I last saw the deceased alive on **July 16**, 1950, and that death occurred at **10:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title) _____	23b. ADDRESS 5201 S. Grand St. St. Louis Mo.	23c. DATE SIGNED 8-3-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-5-50	24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE AUG 4 1950 [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS Kriegshauser-4228 S. Kingshighway Bk.
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

William B. White

Signed.....

Student Embalmer

Licensed Embalmer No. *4291*

P. O. Address *4228 1/2 King Highway*

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.