No. 300
10.48

FILED OCT 21 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36372

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9089

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St.Louis
c. LENGTH OF STAY (in this place) 4-yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address or location) 3225 N.Florissant Ave. Little Sisters of Poor

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St.Louis 2203
d. STREET ADDRESS (If rural, give location) 3225 N.Florissant Ave.

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

4. DATE OF DEATH (Month) (Day) (Year) Sept.29,1952

5. SEX F.
6. COLOR OR RACE W.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S.
8. DATE OF BIRTH Feb.25,1866
9. AGE (In years last birthday) 86 | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fress-maker
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) Griggsville,Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.

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

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Sister Jeane,3225 N.Florissant 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) Chronic Myocarditis — 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) Senility — ???
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 None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify) None
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) None m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 4222

22. *I hereby certify that I attended the deceased from* Sept 15, 1952, *to* Sept 29, 1952, *that I last saw the deceased alive on* Sept 27, 1952, *and that death occurred at* 8 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Edmund W. Foote M.D.
23b. ADDRESS 2435 N. Grand Blvd
23c. DATE SIGNED 9-30-52

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct.1,1952
24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
24d. LOCATION (City, town, or county) (State) St.Louis,Mo.

DATE REC'D BY LOCAL REG. OCT 1 1952
REGISTRAR'S SIGNATURE J. Carl Smith m
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Arthur J. Donnelly 3840 Lindell Blvd.
(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~~ me

..... Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed [illegible]

Licensed Embalmer No. 4699

P. O. Address [illegible]

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.