

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33220**
Registrar's No. **8215**

FILED SEP 24 1953

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____			
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. LENGTH OF STAY (In this place) 2 WKS		c. CITY OR TOWN St Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mo. Baptist Hospital				e. STREET ADDRESS (If rural, give location) 25 1405 Pine				225%	
3. NAME OF DECEASED (Type or Print) a. (First) Harry			b. (Middle) L		c. (Last) Fox		4. DATE OF DEATH (Month) (Day) (Year) Aug 23, 1953		
5. SEX <input checked="" type="radio"/> male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced		8. DATE OF BIRTH Aug 10, 1888		9. AGE (In years last birthday) 65 IF UNDER 1 YEAR Months Days IF UNDER 4 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Union News Co.		11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo.			12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME John J Fox			13b. MOTHER'S MAIDEN NAME Catherine Lewis			14. NAME OF HUSBAND OR WIFE _____			
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. 450-05-5086		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Charles B Fox Rt 2 Arnold, Mo.				
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) Pneumonia with multiple lung abscesses ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS mesenteric thrombosis Conditions contributing to the death but not related to the disease or condition causing death. Gastric resection for benign gastric ulcer						INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION benign gastric ulcer						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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? 521X					
22. I hereby certify that I attended the deceased from 7 Aug 1953 to 23 Aug 1953 , that I last saw the deceased alive on 22 Aug 1953 , and that death occurred at 7:45A m., from the cause and on the date stated above.									
23a. SIGNATURE (Degree or title) Richard Jones MD					23b. ADDRESS 3220 Washington		23c. DATE SIGNED 24 Aug 53		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 8/25/53		24c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery		24d. LOCATION (City, town, or county) (Date) St Louis County, Mo.			
DATE REC'D BY LOCAL REG. AUG 25 1953		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J L Ziegenhein & Sons 7027 Gravois				

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
E. D. Kidwell

Licensed Embalmer No. *3877*

P. O. Address *7027 Graves*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.