

FILED JUN 7 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17005**

BIRTH NO. _____		REG. DIST. NO. <u>310</u>		PRIMARY REG. DIST. NO. <u>3058</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Saint Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Saint Charles</u>		c. LENGTH OF STAY (In this place) <u>3 days</u>		c. CITY OR TOWN <u>Saint Charles</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Saint Joseph's Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>2026 No. 3rd St. 0923</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u>		b. (Middle) <u>Jo</u>		c. (Last) <u>Fund</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 30, 1954</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>		8. DATE OF BIRTH <u>July 14, 1952</u>	
9. AGE (In years last birthday) <u>1</u>		10. UNDER 1 YEAR Months <u>10</u> Days <u>29</u>		11. UNDER 1 MRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Saint Charles, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Harland L. Fund</u>		13b. MOTHER'S MAIDEN NAME <u>Lorraine Heckmann</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Harland L. Fund, St. Charles, Mo.</u>			
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) <u>Congenital Heart Failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Congenital Heart Disease</u> DUE TO (c) <u>① Patent Ductus arteriosus</u> <u>② Ventricular septal defect</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>(Since Birth)</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>7541</u>				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) m.		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>5-24-54</u> to <u>5-30-54</u> , that I last saw the deceased alive on <u>5-30-1954</u> , and that death occurred at <u>9:40 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>R. R. Ruppel M.D.</u>		23b. ADDRESS <u>ST. CHARLES MO</u>		23c. DATE SIGNED <u>June 1, 1954</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>June 1, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Saint Peter's Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Saint Charles, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>June 1 1954</u>		REGISTRAR'S SIGNATURE <u>Fannie Hamilton</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>N.C. Dalloway, St. Charles, Mo.</u>			

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 *Frank R. Amalson*

Licensed Embalmer No. *4*

P. O. Address *St. Cha*

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.