

FILED MAY 12 1955

THE DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

14245

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 548 Registrar's No. 981

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Macoupin</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WEBSTER GROVES</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hettick</u>	
c. LENGTH OF STAY (In this place) <u>2 1/2</u> Months			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>GLENWOOD SANATORIUM</u>		d. STREET ADDRESS (If rural, give location) <u>Rural Route</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>FEARNO,</u>	b. (Middle) <u>CHARLES</u>	c. (Last) <u>HENRY</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April 27, 1955</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>DIVORCED</u>	8. DATE OF BIRTH <u>March 22, 1885</u>	9. AGE (In years last birthday) <u>70</u>	If UNDER 1 YEAR Months Days	If UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Retired 5 years</u>	11. BIRTHPLACE (State or foreign country) <u>Hettick, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Scott Fearn</u>	13b. MOTHER'S MAIDEN NAME <u>Bertha Watt</u>	14. NAME OF HUSBAND OR WIFE <u>Elise Hasterlik Fearn</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Mae Wolverton, Garden Grove, California</u>	ADDRESS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CEREBRAL ARTERIOSCLEROSIS</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>CHRONIC BRAIN SYNDROME ASSOCIATED WITH CEREBRAL ARTERIOSCLEROSIS</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>334X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Feby 9, 1955, to April 27, 1955, that I last saw the deceased alive on April 27, 1955 and that death occurred at 7 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Sharon R. Schmidt M.D.</u>	23b. ADDRESS <u>Glenwood Sanatorium</u>	23c. DATE SIGNED <u>April 27, 1955</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>April 29, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Hagemann, Illinois</u>
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DATE RECD BY LOCAL REG. <u>4/29/55</u>	REGISTRAR'S SIGNATURE <u>Nesley R. Donke, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Shepard Funeral Home, 1167 Hamilton Avenue</u>	ADDRESS
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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 .....  
Student Embalmer

Signed

*Ellen R. Remelund*

Licensed Embalmer No. ....

*4283*

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.