

FILED SEP 8 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27677
7421
Registrar's No.

BIRTH NO. 69550-55 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri 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 Saint Louis Maternity		d. STREET ADDRESS (If rural, give location) 19 4567 Forest Park 21990	
3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last) Foxwell		4. DATE OF DEATH (Month) (Day) (Year) August 8 1955	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH August 7 1955
9. AGE (In years last birthday)		10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St Louis Missouri
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME George Lynell Foxwell		13b. MOTHER'S MAIDEN NAME Grace Billie Culberson	
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)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS	

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		INTERVAL BETWEEN ONSET AND DEATH day 9 hrs 15 min
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Abnormal pulmonary ventilation		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Prematurity DUE TO (c)		
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 checked="" 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? 7744

22. I hereby certify that I attended the deceased from August 7, 1955, to August 8, 1955, that I last saw the deceased alive on August 8, 1955, and that death occurred at 12:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE Robert C. Schauer MD	(Degree or title)	23b. ADDRESS St. Louis Mat. Hosp.	23c. DATE SIGNED 8/16/55
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 8-3-55	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. AUG 24 1955	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Rowland - Allen	ADDRESS 4104 Manchester
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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.....

Licensed Embalmer No.....

P. O. Address.....

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.