

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 29 1955

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State File No. **30820**
Registrar's No. **7565**

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.			
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. LENGTH OF STAY (in this place) 3 1/2 wks.		c. CITY OR TOWN St. Louis		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: Park Lane Hospital				e. STREET ADDRESS (If rural, give location) 5843 Romaine Pl.					
3. NAME OF DECEASED (Type or Print) a. (First) WALTER b. (Middle) E. c. (Last) FEHR			4. DATE OF DEATH (Month) (Day) (Year) Aug. 27, 1955						
5. SEX M		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married		8. DATE OF BIRTH 3-26-1905			
9. AGE (in years last birthday) 50		IF UNDER 1 YEAR Months 5 Days 1		IF UNDER 24 HRS. Hours Min. 					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			10b. KIND OF BUSINESS OR INDUSTRY Machinery			11. BIRTHPLACE (City and State or Foreign Country) O'Fallon, Missouri			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13a. FATHER'S NAME Edward L. Fehr		13b. MOTHER'S MAIDEN NAME Emma Hollender		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. 490-01-3256		17. INFORMANT'S SIGNATURE OR NAME Ruth E. Evans, above			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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary infarction ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hepatic cirrhosis, Edema of both legs due to DUE TO (c) Mycardial insufficiency II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 1 day 1 Mo. 2 Mo.		
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION 422.2			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) (Min.)		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 June 10, 1949 , to August 27, 1955 , that I last saw the deceased alive on Aug. 27, 1955 , and that death occurred at 1:30A m. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Henry E. Rosenberg M.D.				23b. ADDRESS 1467 N. Union Blvd. St. Louis, Mo.		23c. DATE SIGNED 8-29-55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 8-30-1955		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.			
DATE REC'D BY LOCAL REG. AUG 29 1955		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS JAY B. SMITH, Maplewood, Mo.					

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

Student.....
Signature of Student Embalmer

Signed *J.P. Burgess*.....

Licensed Embalmer No. *402*

P. O. Address *Maple*.....

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.