

FILED JUN 12 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17272**

BIRTH NO. _____ REG. DIST. NO. **275** PRIMARY REG. DIST. NO. **3053** Registrar's No. **105**

1. PLACE OF DEATH a. COUNTY Phelps		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Phelps	
b. CITY (If outside corporate limits, write RURAL and give town) Rolla	c. LENGTH OF STAY (In this place) 7 weeks	c. CITY OR TOWN Rolla	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 Phelps Co. Memorial Hospital		STREET ADDRESS (If rural, give location) 505 West 10th. st.	

3. NAME OF DECEASED (Type or Print) a. (First) Samuel	b. (Middle)	c. (Last) Fuld	4. DATE OF DEATH (Month) (Day) (Year) 6-3-1956
---	-------------	-----------------------	---

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1-2-1869	9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
--------------------	-------------------------------	---	----------------------------------	---	------------------------	-----------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Salesman	10b. KIND OF BUSINESS OR INDUSTRY Wholesale Millinery	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
--	--	--	---

13a. FATHER'S NAME Meir Fuld	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Josephine Fuld (wife)
-------------------------------------	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 500-01-7256	17. INFORMANT'S SIGNATURE OR NAME Josephine Fuld, Rolla, Mo.	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, 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) Extreme Eye sanguination		4 hours
	ANTECEDENT CAUSES MORIBUND CONDITIONS, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Meningitis Meningitis Tuberculosis Meningitis DUE TO (c) Carcinoma of Pylorus		6 months
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) (Minute)	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 **4/13** ¹⁹⁵⁶, to **6/3** ¹⁹⁵⁶, that I last saw the deceased alive on **6/3**, 19**56**, and that death occurred at **7:30 P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Wm. [Signature]	23b. ADDRESS Rolla Mo	23c. DATE SIGNED 6/4/56
---	------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 6-5-1956	24c. NAME OF CEMETERY OR CREMATORY New Mt. Sinai Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
--	---------------------------	--	---

DATE REC'D BY LOCAL REG. June 5, 1956	REGISTRAR'S SIGNATURE Nadine L. Stoll	25. FUNERAL DIRECTOR'S SIGNATURE Carl [Signature]	ADDRESS 1100 Elm, Rolla, Mo.
--	--	--	-------------------------------------

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

RECEIVED

Phelps County Health Officer,

County File Number 42

Date Filed MAY 1 1953

MAR 7 1953

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..... *Carl J. Glenn*

Licensed Embalmer No... 470

P. O. Address Ball, ..

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.