

No. 300  
10-48

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

24942

State File No.

FILED JUL 20 1956

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 6073

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 <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) c. CITY OR TOWN <b>St. Louis</b>	d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>P.O.A. City Hospital #1</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Joseph</b> b. (Middle) <b>F.</b> c. (Last) <b>Fallinger</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>June 26, 1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>	8. DATE OF BIRTH <b>August 30, 1941</b>
9. AGE (In years last birthday) <b>14</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Student</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Joseph Fallinger</b>		13b. MOTHER'S MAIDEN NAME <b>LaVerne La Rue</b>	14. NAME OF HUSBAND OR WIFE <b>-----</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. LaVerne Barlog 3940 Dover St.</b>
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <b>Multiple Fractures of the skull. Laceration of Brain; Cervical Fractures suffered when struck by tractor trailer operated by wife, Louis Moquin, while riding bicycled in vicinity of Grand and Bates Sts. about 1038 am., June 26 1956</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>1038 am., June 26 1956</b>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
21a. ACCIDENT (Specify) <b>Accident</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) <b>Street</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>St. Louis Mo.</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>June 26 56 10 am.</b>	21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>813.0</b>	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>1056P</b> m., from the causes and on the date stated above.			
23a. SIGNATURE <b>James M Kelly Deputy</b>		23b. ADDRESS <b>1300 Clark</b>	23c. DATE SIGNED <b>6-27-56</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>June 30, 1956</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>3700 Mt. Olive Road Lemay, Mo.</b>
DATE REC'D BY LOCAL REG. <b>JUN 27 1956</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>C. Hoffmeister U. &amp; L. Co. 7814 S. Broadway</b>	

m. & B. (Licensed Embalmer's Statement on Reverse Side)

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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.....  
Signature of Student Embalmer

Signed *Bill C. Brown*.....

Licensed Embalmer No..... 4

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.