

FILED NOV 15 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37406

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10315**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		a. STATE MISSOURI b. COUNTY ST. LOUIS	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHNS HOSPITAL				Length of stay in 1b 5 days		c. CITY OR TOWN WEBSTER GROVES	
d. STREET ADDRESS 524 GREELEY AVE.				(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				First AUGUSTA		Middle F.	
				Last FEILITZ		4. DATE OF DEATH	
						Month OCT. Day 30 Year 1957.	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 19, 1872	
						9. AGE (In years last birthday) 85	
						IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) GERMANY	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT DR. O. WALTER WAGNER, 524 GREELEY AVE. - W.G. 19,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage, Massive,				DUE TO (b) Generalized arterio-sclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 DAYS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.				DUE TO (c)		Yrs -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331x						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	
20a. ACCIDENT <input type="checkbox"/>		SUICIDE <input type="checkbox"/>		HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY		Hour Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 9/20/51 to 10/30/57 and last saw her alive on 10/30/57 Death occurred at 6 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Shirley Kingrad (Degree or title)				22b. ADDRESS 684 E. Big Bend, 19,		22c. DATE SIGNED 10/31/57	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Removal - Rail		NOV. 15 1957		Roseland Cemetery		Detroit, Michigan	
24. FUNERAL DIRECTOR CALVIN F. FEUTZ FUNERAL HOME, INC. 4828 Natural Bridge Blvd. St. Louis, Mo.				25. DATE RECD. BY LOCAL REG. NOV 1 '57		26. REGISTRAR'S SIGNATURE Earl Smith MD mjs	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300
1-56Health
Welfare
Public
Service

NO. 1-3 P.M.

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 *John A. Williams*

Licensed Embalmer No. 418

P. O. Address *St. Louis*

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.