

Health,
& Welfare
S. Public
th Service

S. 300
v. 1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED NOV 20 1957

STANDARD CERTIFICATE OF DEATH

41988

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar 10728

| | | | | | | | | |
|---|---------------------------|---|---|--|---|--|--|---|
| 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, give TOWNSHIP only) TOWN ST LOUIS | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN ST LOUIS | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF HOSPITAL OR INSTITUTION 318 1079 Central Hospital 1245 a PENROSE | | | Length of stay in lb | STREET ADDRESS 4245 a PENROSE | | | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle G. Last FUCHS | | | 4. DATE OF DEATH Month NOV, Day 11, Year 1957 | | | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Sept. 23, 1894 | 9. AGE (In years last birthday) 63 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASBESTOS WORKER | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) ST LOUIS MISSOURI | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME JOHN FUCHS | | | | 14. MOTHER'S MAIDEN NAME MARY KUPPERSCHMIDT | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. # | 17. INFORMANT Address HELEN FUCHS 4245 a PENROSE | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> Conditions, if any, which gave rise to above cause, (a), stating the underlying cause last. DUE TO (b) <i>Coronary Sclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 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.) 420.1 | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. | | | | | | | | |
| 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 _____ to _____ and last saw her/him alive on _____ Death occurred at 7:27 a. m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <i>Joseph M. Strook, M.D.</i> | | | | 22b. ADDRESS 1360 | | 22c. DATE SIGNED 11/12/57 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 11/13/57 | 23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY | | 23d. LOCATION (City, town, or county) ST LOUIS MISSOURI | | (State) | |
| 24. FUNERAL DIRECTOR STROOT - CARROLL 4600 NATURAL BRIDGE | | | 25. DATE RECD. BY LOCAL REG. NOV 12 57 | | 26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i> M. J. B. | | | |

(Licensed Embalmer's Statement on Reverse Side)

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 *M. W. Renter*.....

Licensed Embalmer No. *486*

P. O. Address *St Louis Mo*

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.