

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-037262  
STATE FILE NUMBER

FILED OCT 30 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10070

S. 300  
1-57

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, give TOWNSHIP only) OR TOWN <b>St. Louis</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>01 4743 Pennsylvania</b>			Length of stay in lb <b>8 years</b>	d. STREET ADDRESS <b>157 4743 Pennsylvania</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Margaret Fendler</b>				First		Last	
4. DATE OF DEATH <b>Oct. 20, 1958</b>				Month		Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 27, 1887</b>		9. AGE (In years last birthday) <b>71</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Frank Rein</b>			13b. MOTHER'S MAIDEN NAME <b>Dora Miller</b>			14. NAME OF HUSBAND OR WIFE <b>Arthur Fendler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Arthur Fendler 4743 Pennsylvania St. Louis,</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertensive cardiovascular disease 1 year</b>							
DUE TO (c) <b>Diabetes mellitus 420.1</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 a.m. p.m.							
20d. INJURY OCCURRED WHILE AT <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 <b>AUG 1956</b> , to <b>OCT 20, 1958</b> and last saw her alive on <b>10-18-58</b> Death occurred at <b>5 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>O Jones M.D.</b> (Degree or title)				22b. ADDRESS <b>3616 S. BDRY, ST. LOUIS</b>		22c. DATE SIGNED <b>10-21-58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)		
<b>Removal</b>		<b>Oct. 23, 1958</b>	<b>Mt. Olive Cemetery</b>		<b>Lemay, Missouri</b>		
24. FUNERAL DIRECTOR <b>C. Hofmeister Mortuaries</b> ADDRESS <b>7814 So. Broadway St., Louis, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>OCT 21 1958</b>		26. REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b> <b>mjb</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.  
All diseases in Part II must be causally related.

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. Branson* .....

Licensed Embalmer No. *4764* .....  
P. O. Address *St. Paul, Minn.* .....

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.