

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038390

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2605

REC'D OCT 20 1958

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u>		c. CITY OR TOWN <u>University City</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis Co Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>908 N. 56th Street</u>	
Length of stay in lb <u>10 Days</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Pasio</u> Middle <u>B.</u> Last <u>Fallis</u>			4. DATE OF DEATH Month <u>10</u> Day <u>10</u> Year <u>1958</u>		
--	--	--	--	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4 1890</u>	9. AGE (In years last birthday) <u>68</u>	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) <u>Plaster</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Const.</u>	11. BIRTHPLACE (City and state or country) <u>Okla.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
---	--	--	--

13a. FATHER'S NAME <u>B. Fallis</u>	13b. MOTHER'S MAIDEN NAME <u>M. B. Sullens</u>	14. NAME OF HUSBAND OR WIFE <u>Ellen Fallis</u>
--	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W.#1</u>	16. SOCIAL SECURITY NO. <u>Unk</u>	17. INFORMANT <u>Ellen Fallis</u>	Address <u>908 N 56th St.</u>
---	---------------------------------------	--------------------------------------	----------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Far Advanced, Active, pulmonary</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9/30/58</u>
DUE TO (b) <u>tuberculosis</u>		
DUE TO (c) <u>002X</u>		<u>10/10/58</u>
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 <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 _____ a.m. _____ p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
---	--	--

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 <u>9-30-1958</u> to <u>10-10-1958</u> and last saw her/him alive on <u>10-10-1958</u> Death occurred at <u>6:15 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <u>Angelo A. Spens M.D.</u>	22b. ADDRESS <u>601 S. Brentwood Clayton</u>	22c. DATE SIGNED <u>10-10-58</u>
---	---	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10-13-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>
---	------------------------------	---	---

24. FUNERAL DIRECTOR <u>J.W. Clark</u>	ADDRESS <u>F.H. 1125 Hodiamont Ave.</u>	25. DATE RECD. BY LOCAL REG. <u>10-10-58</u>	26. REGISTRAR'S SIGNATURE <u>Walter R. Donohue, M.D.</u>
---	--	---	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300

1-57

0

All diseases in Part I 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

Alfred J. Boedecker
Licensed Embalmer No. *2663*
P. O. Address *1195 H. ...*

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.