Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-041531
STATE FILE NUMBER

FILED NOV 20 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10690

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS Mo — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. LOUIS CITY HOSP. — Length of stay in 1b: 25 23
d. STREET ADDRESS (If outside, give location): 1213 ALLEN MARKET — Reside on Farm Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: ST. LOUIS — Inside Limits Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: CHARLES Middle: Last: FEHR

4. DATE OF DEATH Month Day Year: November 5, 1958

5. SEX: Male
6. COLOR OR RACE: WHITE
7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐
8. DATE OF BIRTH: MAY 5 1889
9. AGE (In years last birthday): 69 — 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): RETIRED SPRAY PAINTER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Mo
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: CHARLES FEHR
13b. MOTHER'S MAIDEN NAME: UNKNOWN
14. NAME OF ~~HUSBAND~~ OR WIFE: FLORENCE FEHR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: ALBERT FEHR Address: 3608 ASHBY ROAD

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): BRONCHIAL ASTHMA — INTERVAL BETWEEN ONSET AND DEATH: 5 YRS.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): STATUS ASTHMATICUS — 3 HOURS
DUE TO (c): 241 X
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 ☒ NO ☐ 1

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 FEB 10, 1956, to NOV 5, 1958 and last saw him alive on OCT. 31, 1958
Death occurred at 1:50A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Edward E. Campe, M.D.
22b. ADDRESS: 2202 So. Broadway, St. Louis Mo.
22c. DATE SIGNED: 11/7/58

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: Nov. 7 1958
23c. NAME OF CEMETERY OR CREMATORY: NEW PICKER CEM.
23d. LOCATION (City, town, or county) (State): ST. LOUIS Mo

24. FUNERAL DIRECTOR: Thomas Lutie **ADDRESS:** 2906 Gravois
25. DATE RECD. BY LOCAL REG.: NOV 7 '58
26. REGISTRAR'S SIGNATURE: J. Carl Smith MD
M.D.

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

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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 Samuel C Dill

Licensed Embalmer No. 4347

P. O. Address 2906 Grava

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.