

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-041576

STATE FILE NUMBER

DEC 5 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No. 11024

300 0
1-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Webster Groves
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hosp.		Length of stay in 1b 3 Weeks	d. STREET ADDRESS (If outside, give location) 226 Spring Ave.
3. NAME OF DECEASED (Type or print) First Middle Last JOHN ABRAM FULLER			4. DATE OF DEATH Month Day Year 11-15-1958
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-2-1914
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Mail	11. BIRTHPLACE (City and state or country) St. Louis Mo.
13a. FATHER'S NAME John A Fuller		13b. MOTHER'S MAIDEN NAME Carrie Verena Harris	14. NAME OF HUSBAND OR WIFE Barbara Ann Fuller
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 492-03-4311	17. INFORMANT Address Mrs. Barbara Fuller 226 Spring Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage DUE TO (b) Ruptured aneurysm DUE TO (c) 330X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Rheumatoid arthritis			INTERVAL BETWEEN ONSET AND DEATH 20 days 20 days.
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 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 Feb. 1957 to Nov. 15, 1958 and last saw her alive on Nov. 14, 1958 Death occurred at 5:30 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Type or Print) Birkle Eck M.D.		22b. ADDRESS 950 Francis Place	22c. DATE SIGNED Nov. 17 '58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-17-1958	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
24. FUNERAL DIRECTOR ADDRESS Parker-Aldrich Webster Groves Mo.		25. DATE RECD. BY LOCAL REG. NOV 17 '58	26. REGISTRAR'S SIGNATURE Charles Smith M.D.

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 *Leslie Welch*

Licensed Embalmer No. *4395*

P. O. Address *White Grove*

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.