

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002958  
STATE FILE NUMBER  
2 668  
Registrar's No.

1959 FEB 4 1959 Registration District No. Primary Registration District No.

300  
1-57  
00  
157

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 type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis,</b> 215 <sup>9</sup> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4127a Oregon Ave.,</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>4127a Oregon Ave.,</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Marguerite</b> Middle <b>M.</b> Last <b>Fuller,</b>			4. DATE OF DEATH Month <b>January</b> Day <b>19,</b> Year <b>1959</b>		
--	--	--	--	--	--

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>July 10, 1911</b>	9. AGE (In years last birthday) <b>47</b>	10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS. Hours Min.
--------------------------	-----------------------------------	---	--	--	--	---------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At home,</b>	11. BIRTHPLACE (City and state or country) <b>E. St. Louis, Illinois,</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
---	--	--	---

13a. FATHER'S NAME <b>Michael Morgan,</b>	13b. MOTHER'S MAIDEN NAME <b>Ida Shawn,</b>	14. NAME OF HUSBAND OR WIFE <b>Elmer J. Fuller,</b>
--	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. _____	17. INFORMANT Address <b>Elmer J. Fuller, 4127a Oregon Ave.,</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>Sarcema of stomach</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <b>151X</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 <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. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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>8-27-58</b> to <b>1-19-59</b> and last saw her alive on <b>1-17-59</b> Death occurred at <b>9:20 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE (Degree or title) <b>E. H. Wehlers M.D.</b>	22b. ADDRESS <b>5600 S Compton</b>	22c. DATE SIGNED <b>1-19-59</b>
---	---------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal.</b>	23b. DATE <b>1/22/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery, St. Louis County, Mo.</b>	23d. LOCATION (City, town, or county) (State)
--	-----------------------------	---	---

24. FUNERAL DIRECTOR <b>Gebken-Benz Mortuary,</b>	ADDRESS <b>2842 Meramec St., St. Louis, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>JAN 20 '59</b>	26. REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b>
--	--	---	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

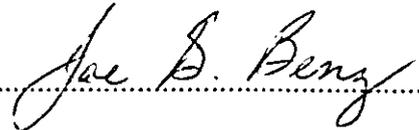
Doctor, coroner, etc. must use only standard nomenclature in their reports. No symptoms which are related to the disease in Part I must be causally related.

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 me....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed .....



Licensed Embalmer No. 4249.....  
2842 Meramec S  
P. O. Address.....St. Louis, 18

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.