

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011698  
STATE FILE NUMBER

FILED APR 6 1959 Registration District No. 317 Primary Registration District No. 546 Registrar's No. 847

300  
-57

Health,  
Welfare  
Public  
Service

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY <b>ST LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>ST LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Overland, Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Overland 4071</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>Hubbart Nursing Home</b>		Length of stay in 1b <b>4 YRS</b>	d. STREET ADDRESS <b>9732 Natural Bridge</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Walter E. Fath</b>			4. DATE OF DEATH Month Day Year <b>Mar. 28, 1959</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>June 11, 1900</b>
9. AGE (In years at birthday) <b>58</b>		10. MONTHS <b>0</b>	11. DAYS <b>0</b>
10a. MAJOR OCCUPATION (Give kind of work done during most of working life, or if retired) <b>ret. Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unk</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Oliver Fath</b>	
13b. MOTHER'S MAIDEN NAME <b>Emma Von Gerichten</b>		14. NAME OF HUSBAND OR WIFE <b>none</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, (state unknown) (When, in what branch of service)) <b>yes World War I</b>		16. SOCIAL SECURITY NO. <b>unk.</b>	17. INFORMANT <b>Irene Oppliger #3</b> Address <b>Sappington MO. 3 PARKWAY DR.</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>Cerebral hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arterio-sclerosis</b> DUE TO (c) <b>Chr. Myocarditis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>4 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chr. Myocarditis</b>			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.) <b>331x</b>		
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
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 <b>Dec 7, 1955</b> to <b>March 28, 1959</b> and last saw him alive on <b>March 28, 1959</b> Death occurred at <b>12:30 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Walter E. Fath</b> (Degree or title)		22b. ADDRESS <b>9385 Page Blvd St. Louis 94, Mo</b>	22c. DATE SIGNED <b>3/29/59</b>
23a. BURIAL, CREMATION, REINTERMENT (State) <b>cremation</b>	23b. DATE <b>3-30-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Crematory</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
24. FUNERAL DIRECTOR <b>Southern Funeral Home</b> <b>6322 S. Grand, St. Louis, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>3-29-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>

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 *James Van Wagoner* .....

Licensed Embalmer No. *4343* .....

P. O. Address *St. Louis, Mo.* .....

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.