

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016279

STATE FILE NUMBER

FILED APR 27 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1110

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Glencoe</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Glencoe</b> <u>4000</u> 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>Glencoe Rd.</b>		Length of stay in lb <b>13 Yrs</b>	d. STREET ADDRESS (If outside, give location) <b>Glencoe Rd.</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Elise</b> Middle <b>Fahr</b> Last <b>Fahr</b>			4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>1959</b>		
--	--	--	---	--	--

5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 19 1874</b>	9. AGE (In years last birthday) <b>85</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>22</b>	IF UNDER 24 HRS. Hours <b>2</b> Min.
-------------------------	----------------------------------	---	--	--	---	---

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

13a. FATHER'S NAME <b>August Schmidt</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Theodore Fahr</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. <b>no</b>	17. INFORMANT <b>Mathilda Baumer</b> Address <b>Glencoe, Mo.</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) <u>myocardial degeneration</u> DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4222</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
---	--	---

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.)	

20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
--	------------------------------	--------	-------

21. I attended the deceased from July 1956 to April 1959 and last saw her alive on 4/17/59.  
Death occurred at 9:00 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>F.C. Mc Murray M.D.</u>	22b. ADDRESS <u>Ballwin, Mo.</u>	22c. DATE SIGNED <u>4/28/59</u>
--	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4-24-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bethlehem Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>
--	-----------------------------	---	--

24. FUNERAL DIRECTOR <b>Schrader Funeral Home</b> ADDRESS <b>Ballwin Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>4-22-59</b>	26. REGISTRAR'S SIGNATURE <u>John P. Murphy, MD</u>
---	--	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Richard Bopp* .....

Licensed Embalmer No. *4584*  
P. O. Address *Baltimore, Md.*

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.