

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-0228661  
STATE FILE NUMBER  
2 5584

FILED JUN 24 1959 Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

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-57  
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS Mo</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>ST. LOUIS</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>4504 ARSENAL</i>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <i>4504 ARSENAL</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <i>WILLIAM D. FAGUE JR.</i>			4. DATE OF DEATH Month Day Year <i>JUNE 9 1959</i>		
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5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>SEPT. 19 1903</i>	9. AGE (In years last birthday) <i>55</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 2 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BREWERY WORKER</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>BUSCH BREWERY</i>	11. BIRTHPLACE (City and state or country) <i>MASSACHUSETTS</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13a. FATHER'S NAME <i>WILLIAM D. FAGUE</i>	13b. MOTHER'S MAIDEN NAME <i>VICTORIA RICHARD</i>	14. NAME OF HUSBAND OR WIFE <i>FRIEDA FAGUE (DEC'D)</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>YES WAR I</i>	16. SOCIAL SECURITY NO. _____	17. INFORMANT <i>MARYANN FAGUE</i> Address <i>5510 GHIPPEWA</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Calculus of Bowel</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	1539
	DUE TO (c) _____	

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"/>
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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.)
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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
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21. I attended the deceased from Death occurred at <i>Lawrence</i> on <i>6/7/59</i> and last saw her alive on <i>6/7/59</i>	22a. SIGNATURE (Degree or title) <i>W. J. Phelps</i>	22b. ADDRESS <i>274 Francis</i>	22c. DATE SIGNED <i>6/10/59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	23b. DATE <i>JUNE 11 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>RESURRECTION CEM.</i>	23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS, MO</i>
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24. FUNERAL DIRECTOR <i>Thomas Kutsa</i> ADDRESS <i>2906 Francis</i>	25. DATE RECD. BY LOCAL REG. <i>JUN 11 '59</i>	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

C.P.

REC 1-14-26  
Re-Viewed at 6:30 P.M. W.A.E.

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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address Jennings

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.