RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–030390

FILED VS SEP 4 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 7799 STATE FILE NUMBER

DED

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: City of St. Louis — Length of stay in 1b

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 939 Utah. — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri — b. COUNTY

c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location): 939 Utah — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Martin — Last: Fox III

4. DATE OF DEATH: Month: August — Day: 21 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: Dec 22-1889

9. AGE (last birthday): 62 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HR: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Millwright (Ret)

10b. KIND OF BUSINESS OR INDUSTRY: Mfg.

11. BIRTHPLACE (City and state or country): Peral Ill

12. CITIZEN OF WHAT COUNTRY: U.S.A

13a. FATHER'S NAME: Charles Fox I

13b. MOTHER'S MAIDEN NAME: Anna Bell

14. NAME OF HUSBAND OR WIFE: Dolly Sago Fox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 499-05-0409

17. INFORMANT: Mrs Dolly Fox — Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), an

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinoma of Left Lung — INTERVAL BETWEEN ONSET AND DEATH: ?

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Duodenal ulcer — 3

DUE TO (c): 163X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 April 1-1959, to Aug 21-1959 and last saw ~~her~~ him alive on Aug 21-1959

Death occurred at 6:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): H. J. Moore MD.

22b. ADDRESS: 917-5018

22c. DATE SIGNED: 8-22-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 8/24-1959

23c. NAME OF CEMETERY OR CREMATORY: Herod Cemetery

23d. LOCATION (City, town, or county) (State): St. Francois Co. Mo

24. FUNERAL DIRECTOR — ADDRESS: C. J. Boyer & Son Desloge Mo

25. DATE RECD. BY LOCAL REG.: AUG 24 '59

26. REGISTRAR'S SIGNATURE: Carl Smith. M.D.

(Licensed Embalmer's Statement on Reverse Side)

S.P.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed b

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed B. T. Bayer.

Signature of Student Embalmer

Licensed Embalmer No. 366

P. O. Address Desloge,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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.