

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# 59-031030

FILED VS AUG 26 1959 317

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 2207

STATE FILE NUMBER

IDED

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St Louis</u>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WEBSTER GROVES</u>		Length of stay in 1b <u>6 YRS</u>		c. CITY OR TOWN <u>WEBSTER GROVES 19</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 <u>657 CLARK AVE</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>657 CLARK AVE</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA LYDIA FRUIN</u>				4. DATE OF DEATH Month Day Year <u>8 15 1959</u>						
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>7-29-1862</u>	9. AGE (last birthday) <u>95</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>16</u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>			10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (City and state or country) <u>SUMMERFIELD ILL</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>			
13a. FATHER'S NAME <u>MOSES F MOORE</u>			13b. MOTHER'S MAIDEN NAME <u>CAROLINE C. CASAD</u>			14. NAME OF HUSBAND OR WIFE <u>CHARLES E FRUIN</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>James C Fruin 657 Clark Ave</u>			Address		
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>Hemorrhage from an intracranial vessel</u>							INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Hypertensive cardio-vascular disease</u>					many years			
DUE TO (c) <u> </u>		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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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 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 <u>Aug 14, 1959</u> to <u>Aug 15, 1959</u> and last saw her alive on <u>August 14, 1959</u> Death occurred at <u>11:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE <u>James B Jones</u> (Degree or title) <u>M.D.</u>				22b. ADDRESS <u>337 W Lockwood Ave, Webster Groves 19, Mo</u>				22c. DATE SIGNED <u>8-17-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE <u>8-18-'59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAK GROVE CREMATORY</u>		23d. LOCATION (City, town, or county) <u>St Louis Co</u>		(State) <u>Mo</u>		
24. FUNERAL DIRECTOR <u>MITTELBURG</u>				ADDRESS <u>WEBSTER GROVES MO</u>		25. DATE RECD. BY LOCAL REG. <u>8-17-59</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

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

~~or by~~ \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Elton R. H. Pennington

Licensed Embalmer No. 4283

P. O. Address St. Louis

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