URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 22 1959

59-033804

STATE FILE NUMBER

ENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 8424

1. PLACE OF DEATH
a. COUNTY

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

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Length of stay in 1b 15 yrs.

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

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

d. STREET ADDRESS (If outside, give location) 4855 Fountain — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Charles — Middle — Last Foxwell

4. DATE OF DEATH Month 9 Day 9 Year 59

5. SEX Male

6. COLOR OR RACE Colored

7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☒

8. DATE OF BIRTH 6-17-1906

9. AGE (last birthday) 53 — IF UNDER 1 YEAR Months 3 Days 22 — IF UNDER 24 HR Hours Min.

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

10b. KIND OF BUSINESS OR INDUSTRY Shoe Company

11. BIRTHPLACE (City and state or country) Providence, Kentucky

12. CITIZEN OF WHAT COUNTRY USA.

13a. FATHER'S NAME Abe Foxwell

13b. MOTHER'S MAIDEN NAME Mattie Pearson

14. NAME OF HUSBAND OR WIFE None

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

16. SOCIAL SECURITY NO. 294-07-9444

17. INFORMANT Margaret Foxwell — Address 4855 Fountain

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH Undet.

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

DUE TO (b) Arteriosclerosis

DUE TO (c)

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

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 8-28-59, to 9-9-59 and last saw him alive on 9-9-59

Death occurred at 10:50 p.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Sydney G. Grasse, M. D.

22b. ADDRESS 2601 N. Whittier St.

22c. DATE SIGNED 9-10-59

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

23b. DATE 9-15-1959

23c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery

23d. LOCATION (City, town, or county) St Louis, County (State) Mo.

24. FUNERAL DIRECTOR Thelma Watson Hudson — ADDRESS 2764 Choutcau

25. DATE RECD. BY LOCAL REG. SEP 1 2 '59

26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 by me

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Oswald A Jameson

Licensed Embalmer No. 5011

P. O. Address 506 Wallo

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