

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033816

FILED VS OCT 15 1959

2 9102

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

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|---|--|---|--|---|--|---|---|--|
| 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 | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony's Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 3520 Chippewa Avenue | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle A Last Fullweber | | | | 4. DATE OF DEATH Month October Day 3 Year 1959 | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 11-3-1886 | 9. AGE (last birthday) 72 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kitchen Duties | | 10b. KIND OF BUSINESS OR INDUSTRY St. Anthony's Hosp. | | 11. BIRTHPLACE (City and state or country) St. Louis, Missouri | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | |
| 13a. FATHER'S NAME Jacob Fullweber | | | 13b. MOTHER'S MAIDEN NAME Kentsinger | | | 14. NAME OF HUSBAND OR WIFE None | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 493-36-9543 | | 17. INFORMANT Address Miss Madeline Hammes - 4934 Genevieve Ave | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Arterio-sclerotic heart DUE TO (c) Disease with hypertension Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days 2 yrs | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Cholelithiasis with Hydrops of Gall Bladder (surgery 9/20/59) | | | | | | 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 checked="" type="checkbox"/> NO <input type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> | SUICIDE <input type="checkbox"/> | HOMICIDE <input type="checkbox"/> | 20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.) | | | | |
| 20c. TIME OF INJURY Hour s.m. p.m. | | Month, Day, Year 7 20 0 | | | | | | |
| 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 St. Louis | | COUNTY St. Louis | | |
| 21. I attended the deceased from January '58 to October 3, '59 and last saw her alive on Oct. 2-1959 Death occurred at 345 a m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) George A. Sullivan, M.D. | | | | 22b. ADDRESS 7629 Ivory Ave. | | 22c. DATE SIGNED 10-3-59 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Oct. 5, 1959 | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 23d. LOCATION (City, town, or county) St. Louis, Missouri | | | |
| 24. FUNERAL DIRECTOR ADDRESS Math Hermann & Son, Inc., 2161 E. Fair Av | | | | 25. DATE RECD. BY LOCAL REG. 10-3-1959 | | 26. REGISTRAR'S SIGNATURE Loan Smith, M.D. | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

mdb

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

Hughes & Bussell

Licensed Embalmer No. 4205

P. O. Address Spencer

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.