

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

-60-009133

FILED VS MAR 3 1960

317

544

626

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirkwood		Length of stay in 1b 1 Week	c. CITY OR TOWN Sappington Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 10933 Kennerly Rd. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First PHILIP Middle H. Last FUCHS			4. DATE OF DEATH Month Feb. Day 23 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-12-1893	9. AGE (last birthday) 66	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) Salesman-West End Motors Co.		10b. KIND OF BUSINESS OR INDUSTRY St. Louis County, Mo.		11. BIRTHPLACE (City and state or country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Michael H. Fuchs		13b. MOTHER'S MAIDEN NAME Elizabeth Eiler		14. NAME OF HUSBAND OR WIFE Alma Fuchs		
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. 490-36-5625		17. INFORMANT Address Alma Fuchs 10933 Kennerly Rd.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Bronchopneumonia left		1 week
DUE TO (b) Obstruction left main bronchus		yes
DUE TO (c) Aspirated & regurgitated contents of stomach & compression of trachea		9 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Graft thoracic aorta, Post-operative hypertension, severe esophageal stricture		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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"/>	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 **2/17/60** to **2/23/60** and last saw her alive on **2/22/60**
 Death occurred at **7:10 A.** m of the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE **James C. Vest m.d.** (Degree or title) 22b. ADDRESS **634 N. Grand** 22c. DATE SIGNED **2/22/60**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE **Feb. 26, 1960** 23c. NAME OF CEMETERY OR CREMATORY **Assumption Cemetery** 23d. LOCATION (City, town, or county) **Mattese, Mo.** (State)

24. FUNERAL DIRECTOR ADDRESS **Kriegshauser 4228 S.Kingshighway** 25. DATE RECD. BY LOCAL REG. **2-24-60** 26. REGISTRAR SIGNATURE **[Signature]**

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 William B White

Licensed Embalmer No. 4291

P. O. Address 2200 1/2 Kings

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.