

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-028315

FILED 19 AUG 10 1960

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6665** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN University City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital #1		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 749 Heman Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) AKA First Fannette Middle Lee Scherberg Last FANNY FRANK			4. DATE OF DEATH Month June Day 30 Year 1960		
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 4/19/1943	9. AGE (last birthday) 17	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY High School	11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Isadore Frank		13b. MOTHER'S MAIDEN NAME Adelaide Weiss		14. NAME OF HUSBAND OR WIFE —	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mr. Jay Stupp 519a Hamilton Ave.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY: **Subdural hemorrhage; Compound comminuted fractures causing a hemorrhage into the left pleural cavity, which was filled to brim; suffered when car operated by Robert Kiser, in which deceased was a passenger, went out of control in front of about 4600 Bircher Blvd. about 12:10A.M. June 30, 1960 Accident**

IMMEDIATE CAUSE (a) **fractures causing a hemorrhage into the left pleural cavity, which was filled to brim; suffered when car operated by Robert Kiser, in which deceased was a passenger, went out of control in front of about 4600 Bircher Blvd. about 12:10A.M. June 30, 1960 Accident**

CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.

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 <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) (SEE ABOVE)
20c. TIME OF INJURY Hour 12:10 a.m. pm Month, Day, Year 6-30-60		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 07 street	20f. CITY, TOWN, OR LOCATION St. Louis, Mo.	COUNTY	STATE
21. I attended the deceased from 2:00 A. to 2:00 A. and last saw her him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Deceased or title) Fannette Lee Scherberg		22b. ADDRESS 1300 Cherokee	22c. DATE SIGNED 7/1/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7/3/1960	23c. NAME OF CEMETERY OR CREMATORY B'nai Amoona	23d. LOCATION (City, town, or county) (Specify) University City, Mo
24. FUNERAL DIRECTOR ADDRESS Berger Memorial 4715 McPherson Avenue		25. DATE RECD. BY LOCAL REG. JUL 1 1960	26. REGISTRAR'S SIGNATURE Sean Smith, M.D. Jn B. B.

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 *[Handwritten Signature]*

Licensed Embalmer No. 3988

P. O. Address _____

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.