

Registration-District No. 318 Primary Registration District No. 1003 Registrar's No. 9455

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns Hospital		d. STREET ADDRESS 1014 Remondel St. Alverne Hotel	

3. NAME OF DECEASED (Type or print) First Middle Last Louis Fox			4. DATE OF DEATH Month Day Year Sept. 26, 1960		
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5. SEX male	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 8-25-1887	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Louis Fox	13b. MOTHER'S MAIDEN NAME Louise Schwarz	14. NAME OF HUSBAND OR WIFE none
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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. 499-36-9728	17. INFORMANT James C. Jennings 706 Chestnut
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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) <i>Arteriosclerotic Heart Disease</i>		<i>unknown</i>
DUE TO (b) <i>Generalized Arteriosclerosis</i>		<i>unknown</i>
DUE TO (c) <i>420.0</i>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Central Arteriosclerosis, Hypertension, Cryptosporidiosis</i>		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	
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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.)
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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
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21. I attended the deceased from 9-17-60 to 9-26-60 and last saw her ^{her} alive on 9-25-60
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Death occurred at 945 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Joseph V. O'Donnell M.D.</i>	22b. ADDRESS 539 N. Grand, St. Louis 3, Mo	22c. DATE SIGNED 9/27/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 9-29-60	23c. NAME OF CEMETERY OR CREMATORY Calvary Cem.	23d. LOCATION (City, town, or county) St. Louis, Mo.
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24. FUNERAL DIRECTOR Southern Funeral Home 6222 S. Grand, St. Louis, Mo.	25. DATE RECD. BY LOCAL REG. SEP 27 1960	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Her J A O Donnell
539 N Grand
before 1 P.M.

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

Herbert J. Ganis

Licensed Embalmer No. 4800

P. O. Address Kirkwood

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.