

**JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED **NOV 2 1960**

**60-040628**  
STATE FILE NUMBER

Registration District No. **317** Primary Registration District No. **500** Registrar's No. **3022**

1. PLACE OF DEATH a. COUNTY <b>St. Louis County</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <del>City</del>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b <b>MONS.</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Halls Ferry Nursing Home</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1014 Fairmount Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>BLANCHE</b> Middle <b>FONTANA</b> Last				4. DATE OF DEATH Month <b>Oct</b> Day <b>16</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9/3/1888</b>	
				9. AGE (last birthday) <b>72</b>		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) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis Missouri</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>							
13a. FATHER'S NAME <b>Louis Fontana</b>				13b. MOTHER'S MAIDEN NAME <b>Catherine DeVoto</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>497-07-6953</b>		17. INFORMANT Address <b>Kathryn Graff 1014 Fairmount Avenue</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic Heart disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Old cerebral thromboses</b>						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 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.)			
20c. TIME OF INJURY Hour _____ 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 <b>June 9, 1956</b> to <b>Oct 16, 1960</b> and last saw her alive on <b>Oct 14, 1960</b> Death occurred at <b>3:55 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Lewis Lettmann MD</b>				22b. ADDRESS <b>8231 Clayton Rd (17)</b>		22c. DATE SIGNED <b>10/17/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>10/18/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Kriegshauser 9450 Olive Street Rd. (32)</b>				25. DATE RECD. BY LOCAL REG. <b>10-18-60</b>		26. REGISTRAR'S SIGNATURE <b>J. M. Murphy</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

*James J. Kneplauer*

Licensed Embalmer No. 5101

P. O. Address 9450 Olive St

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.