URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS DEC 14 1960

-60-043566

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11773

NDED

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS MISSOURI — Length of stay in 1b: 7 hr. 40 min

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): JEWISH HOSPITAL — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: St. Louis

c. CITY OR TOWN: ~~ST. LOUIS 20~~ — Inside Limits: Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location): 3808 LAWLER DR. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First / Middle / Last: FENDER

4. DATE OF DEATH: Month 11 - Day 9 - Year 60

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. Married ☐ Widowed ☐ Never Married ☒ Divorced ☐

8. DATE OF BIRTH: 11-8-60

9. AGE (last birthday): IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HR: Hours 7 Min. 40

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): ST. LOUIS, MO

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: JACK CLINTON FENDER

13b. MOTHER'S MAIDEN NAME: LINDA JO BLACKWOOD

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):

16. SOCIAL SECURITY NO.:

17. INFORMANT: LINDA FENDER — Address: 3808 LAWLER DR. ST. LOUIS 20, MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 7 hr. 40'

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Prematurely

DUE TO (c): 762.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Subarachnoid Hemorrhage

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 Birth, to death. and last saw her/him alive on 11-9-60

Death occurred at 4:30 am m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Coach Sussman MD

22b. ADDRESS: 100 N Euclid

22c. DATE SIGNED: 11-17-60

23a. BURIAL, CREMATION, REMOVAL (Specify):

23b. DATE: 12-31-60

23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board

23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR: Rowland-Aker — ADDRESS: 4104 Manchester

25. DATE RECD. BY LOCAL REG.: DEC 8 1960

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

DOCUMENT

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com
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.