

FILED NOV 17 1960

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--|
| 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 | | Length of stay in 1b 30 Years | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Christian Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 5707 McPherson Ave | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Grace Gertrude Hacker | | | | 4. DATE OF DEATH Month November Day 8 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 9/20/1876 | 9. AGE (last birthday) 84 | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Filing Clerk (Retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY Graham Paper Co | | 11. BIRTHPLACE (City and state or country) Thornton, Indiana | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME William Albert Hacker | | | 13b. MOTHER'S MAIDEN NAME Amanda Spear | | | 14. NAME OF HUSBAND OR WIFE None | | |
| 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. 494-07-6813 | | 17. INFORMANT Address Miss Cora B. Hacker 5707 McPherson | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforation of duodenal ulcer <i>Perforation of duodenal ulcer</i> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 - 11 | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 541.1 | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ulcerative colitis | | | | | | 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 _____ 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.) 10-31-60 | | 20f. CITY, TOWN, OR LOCATION 11-8-60 | | COUNTY 11-7-60 STATE | | |
| 21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at 10 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE G. J. Fuchs (Degree or title) M.D. | | | | 22b. ADDRESS 608 Kingsland | | | 22c. DATE SIGNED | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal (Rail) | | 23b. DATE 11/10/60 | 23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery | | 23d. LOCATION (City, town, or county) (State) Orleans, Indiana | | | |
| 24. FUNERAL DIRECTOR Alexander & Sons 6175 Delmar Blvd | | | | 25. DATE RECD. BY LOCAL REG. NOV 9 1960 | | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. | | |

DEC 13 1960

Dr. G. J. Fuchs
608 Kingsland Ave

Pa. 1-8400
Unti 6 P.M.

VS DEC 14 1960

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 Joe J. McCulloch
Licensed Embalmer No. 2460

P. O. Address 6107 1/2 Rd

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.