SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-027632

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1882

FILED JUL 19 1961

1. PLACE OF DEATH
a. COUNTY Saint Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Normandy — Length of stay in 1b: 1 day
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Normandy Osteopathic Hosp. — Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Illinois b. COUNTY
c. CITY OR TOWN East Alton — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS Rt. 1 (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Ida; Middle Elizabeth; Last Fahnestock
4. DATE OF DEATH: Month July; Day 5; Year 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 4-17-1879
9. AGE (last birthday): 81
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): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: U SA
13a. FATHER'S NAME: Rudolph Ufen
13b. MOTHER'S MAIDEN NAME: Sophie Piening
14. NAME OF HUSBAND OR WIFE: LeRoy
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Jane Fahnestock-3106a Frow Ct.

MEDICAL CERTIFICATION

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)	Cerebro vascular Accident	Min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Embolic Showes	min
DUE TO (c)	Auricular Fibrillation	Days.

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

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 4/9/61, to 7-5-61 and last saw her/him alive on 7-5-61
Death occurred at 4:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE William D McGavran Jr MD (Degree or title)
22b. ADDRESS 7811 Carondelet-Clayton 5, Mo.
22c. DATE SIGNED 7-6-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 7-8-61
23c. NAME OF CEMETERY OR CREMATORY: St. John's
23d. LOCATION (City, town, or county) (State): St. Louis Co. Mo.

24. FUNERAL DIRECTOR: Leslie Marks ADDRESS: Edwardsville, Ill.
25. DATE RECD. BY LOCAL REG.: 7-6-61
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | 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 me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Harry E Inantal

Signature of Student Embalmer

Licensed Embalmer No. 4495

P. O. Address St Louis

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.