MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-012622
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2973

FILED MAR 26 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Mo.
Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION: St. Louis City Hosp#1 — Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 1211 N. Market St. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Margaret Middle: Last: Fahr

4. DATE OF DEATH: Month: March Day: 19 Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed XX Divorced ☐
8. DATE OF BIRTH: 1-31-1882
9. AGE (last birthday): 80 — 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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (City and state or country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Conrad Leben
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: –

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: Virginia Anderson Address: Washington, D.C.

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): Mesenteric thrombosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 570.2H
INTERVAL BETWEEN ONSET AND DEATH

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

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 3/13/62, to 3/19/62 and last saw her/him alive on 3/19/62
Death occurred at 1:45 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Paul L. Beatty (Degree or title) M.D.
22b. ADDRESS: 1515 Lafayette, Ave.
22c. DATE SIGNED: 3/19/62

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 3-21-62
23c. NAME OF CEMETERY OR CREMATORY: Rose Lawn Memorial
23d. LOCATION (City, town, or county) (State): Crystal City, Mo.

24. FUNERAL DIRECTOR: Gentry R. Politte ADDRESS: Crystal City, Mo.
25. DATE RECD. BY LOCAL REG.: MAR. 19 1962
26. REGISTRAR'S SIGNATURE: Pearl Smith, M.D.

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 Gentry R Pohlitz

Signature of Student Embalmer

Licensed Embalmer No. 3481

P. O. Address Crystal City Mo

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.