

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

6-62-020399

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District **1003** Registrar's No. **5582** STATE FILE NUMBER

FILED JUN 7 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

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DATE AMENDED
INSTEAD OF
SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

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	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO.		b. COUNTY St. Louis		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cardinal Glennon		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 6949 a Manchester, St. Louis		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle R. Last Fozzy			4. DATE OF DEATH Month 6 Day 3 Year 62		5. SEX Male		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 3-7-62		9. AGE (last birthday) 2 1/2 mos		IF UNDER 1 YEAR Months 2 Days		IF UNDER 24 HR Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME James Russell Fozzy			13b. MOTHER'S MAIDEN NAME LIMNEY BURN		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) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT JAMES FOZZY 6949th MANCHESTER		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Concussion of Aorta Patent Aortic Aneurysm Aortic Stenosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Patent Aortic Aneurysm DUE TO (c) Aortic Stenosis								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) 754.1						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 10:00pm Month, Day, Year 5-25-62		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21. I attended the deceased from 5-25-62 to 6-3-62 and last saw her/him alive on 6-3-62 . Death occurred at 10:00pm on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Francis P. Smith, M.D. (Degree or title)			22b. ADDRESS 950 Francis Pl.			22c. DATE SIGNED 6-4-62			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 6-5-62	23c. NAME OF CEMETERY OR CREMATORY OAK HILL CEM.		23d. LOCATION (City, town, or county) ST. LOUIS CO. MO.		(State)		
24. FUNERAL DIRECTOR KRIEGSHAUSER 4228 S. KINGS HIGHWAY			25. DATE RECD. BY LOCAL REG. JUN 4 1962		26. REGISTRAR'S SIGNATURE Francis P. Smith, M.D.				

USE BLACK INK OR TYPEWRITER RIBBON

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 _____
Signature of Student Embalmer

Signed R. W. Stovesand

Licensed Embalmer No. 4007

P. O. Address _____

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.