

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-028621

STATE FILE NUMBER

DO NOT WRITE ON THIS STUD

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7593**

FILED AUG 6 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN Wellston	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital		d. STREET ADDRESS (If outside, give location) 7301 St. Charles Rock, Rd.	
3. NAME OF DECEASED (Type or print) First Gretchen Middle Helen Last Fegers		4. DATE OF DEATH Month July Day 30 Year 1962	
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 4/8/1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper St. Vincent Hospital		11. BIRTHPLACE (City and state or country) McHenry, Illinois.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Charles B. Fegers		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.		17. INFORMANT Mrs. Lillian Berberet, 1229 Grand, Ave.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) 331X DUE TO (c) 331X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 8:50 P.M. Month, Day, Year Sept 1955		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.)		20f. CITY, TOWN, OR LOCATION Keokuk, Iowa.	
21. I attended the deceased from Sept 1955 to July 30, 1962 and last saw her alive on July 30, 1962 Death occurred at 8:50 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.		22b. ADDRESS 8720 Washington	
22a. SIGNATURE (Degree or title) Ch. Woumen MD		22c. DATE SIGNED 7-31-62.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7-31-62	23c. NAME OF CEMETERY OR CREMATORY Catholic Cemetery	23d. LOCATION (City, town, or county) (State) Keokuk, Iowa.
24. FUNERAL DIRECTOR Albert H. Hoppe Inc., 4700 Washington, Blvd.		25. DATE REC'D. BY LOCAL REG. JUL 31 1962	
26. REGISTRAR'S SIGNATURE Roald Smith, M.D.			

APR 9 1963

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 J. W. Brubaker

Licensed Embalmer No. 3653

P. O. Address St Louis, 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.