

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-028623

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7425

STATE FILE NUMBER

FILED AUG 6 1962

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL #1</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>5455 Delmar</b>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES FEMMER</b>			4. DATE OF DEATH Month Day Year <b>JULY 26 62</b>			5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>				
8. DATE OF BIRTH <b>5/1/1899</b>		9. AGE (last birthday) <b>63</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Selfemployed</b>				
11. BIRTHPLACE (City and state or country) <b>Truxton, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Albert August Femmer</b>			13b. MOTHER'S MAIDEN NAME <b>Anna Witthaus</b>			14. NAME OF HUSBAND OR WIFE <b>Ethel Lucille Woodson</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>						17. INFORMANT Address <b>Mrs. Ethel L. Femmer 5455 Delmar Blvd.</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis of Distal Aorta + Coronary iliac arteries due to arteriosclerosis</b> DUE TO (b) _____ DUE TO (c) <b>45:00</b>			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)						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 checked="" type="checkbox"/> NO <input type="checkbox"/>			20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)								
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		COUNTY		STATE				
21. I attended the deceased from <b>7-11-62</b> to <b>7-26-62</b> and last saw her/him alive on <b>7-26-62</b> Death occurred at <b>9:15 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.						22a. SIGNATURE (Degree or title) <i>Joseph J. Tucker M.D.</i>			22b. ADDRESS <b>1515 LAFAYETTE AVENUE</b>			22c. DATE SIGNED <b>7-27-62</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county)			(State)				
<b>Removal</b>		<b>7/27/62</b>		<b>Zion Methodist Cemetery</b>			<b>Truxton</b>			<b>Mo.</b>				
24. FUNERAL DIRECTOR <b>Jos. Marsh Funeral Home</b>						ADDRESS <b>Troy, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>JUL 28 1962</b>		26. REGISTRAR'S SIGNATURE <i>Roan Smith M.D.</i>			

**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 jos emicullo

Licensed Embalmer No. 2460

P. O. Address 6730 11th

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.