

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-029427

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2067

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

14042

2 21

3

4 0

5 2

6

7 0

8 2

9332X

10

11

1286-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED AUG 3 1962		1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>ST. LOUIS</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Valley Park</u>		a. STATE <u>Mo</u> b. COUNTY _____	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Valley Park Nursing Home</u>		Length of stay in 1b <u>-</u>		c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		d. STREET ADDRESS (If outside, give location) <u>3224<sup>th</sup> MICHIGAN</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
First <u>FRANK</u> Middle <u>J.</u> Last <u>FELHAUER</u>		Month <u>JULY</u> Day <u>14</u> Year <u>1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 31, 1915</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED WATCHMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>ADAM FELLHAUER</u>		13b. MOTHER'S MAIDEN NAME <u>SARAH HITZMAN</u>		14. NAME OF HUSBAND OR WIFE <u>LOUISE FELLHAUER</u> (Spec'd)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT Address <u>EDNA BOEMEKE 3224<sup>th</sup> MICHIGAN</u>	
18. CAUSE OF DEATH (Enter only one cause per line if PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
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 type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m. Month, Day, Year _____		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 <u>June 27, 1962</u> to <u>July 14, 1962</u> and last saw <sup>her</sup> him alive on <u>July 12, 1962</u> . Death occurred at <u>13<sup>th</sup> A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>[Signature]</u> (Degree or title) _____		22b. ADDRESS <u>1502 Cass Av</u>		22c. DATE SIGNED <u>7-14-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>July 16, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>S. S. Peter &amp; Paul Cem.</u>	
24. FUNERAL DIRECTOR <u>Thomas Kulis 2906 Grevious</u>		25. DATE RECD. BY LOCAL REG. <u>7-15-62</u>		23d. LOCATION (City, town, or county) <u>ST. LOUIS</u> (State) <u>Mo</u>	
		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

USE BLACK INK OR TYPEWRITER RIBBON

*Dr. Pearson*  
*1502 East*  
*611 12 Ave, St.*

**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 *Eleanor Province*

Licensed Embalmer No. *3403*

P. O. Address *2906 Gravois*

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.