

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

9660-62-040218

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9660

FILED OCT 19 1962

VS 300  
Rev. 4/59

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		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>1 Wk.</b>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Faith Hospital</b>		c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		d. STREET ADDRESS (If outside, give location) <b>4219 Dressell Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ernst</b> Middle <b>G.</b> Last <b>Fritz</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>7</b> Year <b>1962</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>2-15-98</b>
9. AGE (last birthday) <b>64</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>Assembler (ret.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fisher Body Co.</b>	11. BIRTHPLACE (City and state or country) <b>Lebanon, Ill.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Philip Fritz</b>	
13b. MOTHER'S MAIDEN NAME <b>Elizabeth Schildknecht</b>		14. NAME OF HUSBAND OR WIFE <b>Viola S. Fritz</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>		16. SOCIAL SECURITY NO. <span style="border: 1px solid black; padding: 2px;">[REDACTED]</span>	
17. INFORMANT <b>Mrs. Viola S. Fritz, Dressell</b>		Address <b>4219</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute monocytic leukemia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>204.2</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 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 _____ 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.) <b>11/1/52</b>	20f. CITY, TOWN, OR LOCATION <b>10/7/62</b>	COUNTY _____ STATE _____
21. I attended the deceased from _____ to _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.		and last saw him alive on <b>10/7/62</b>	
22a. SIGNATURE <b>Robert A. Bauer MD</b> (Degree or title)		22b. ADDRESS <b>Northland Med Bldg</b>	
22c. DATE SIGNED <b>10/8/62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal (motor)</b>	23b. DATE <b>10-11-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>College Hill Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Lebanon Ill.</b>
24. FUNERAL DIRECTOR <b>Drehmann-Harral, 1905 Union Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>OCT 9 1962</b>	
		26. REGISTRAR'S SIGNATURE <b>Paul Smith MD</b>	

Dr. Robert A. Bauer  
Northland Med. Bldg.  
Co 1-7302  
Hrs. 12:30 - 2 PM

**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 Warren A. Carver

Licensed Embalmer No. 3534

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.