MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

~~20896~~ 20708

File No. 20708

Registered No. 5500

1. PLACE OF DEATH

County ..... Registration District No. 7911

Township ..... Primary Registration District No. 10013

City St Louis Mo (No. ..... City Hosp #2 ..... St. ..... Ward)

2. FULL NAME Tom Fancher Tom Fancher

(a) Residence: No. 110 S. Springwell St., 22 Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	Col	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-25-1887

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	43	-	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Kansas

PARENTS

10. NAME OF FATHER John Fancher

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Tenn

14. INFORMANT A. Gertrude Creath
(Address) City Hospital #2

15. FILED 1-6 19 Harry C. Harlen
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-4 1930

17. I HEREBY CERTIFY, That I attended deceased from 6-2-30, 19..., to 6-4, 1930, that I last saw h. alive on 6-3, 1930, and that death occurred, on the date stated above, at 4:40 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: 4/A

Pulmonary Embolism
12/A
11/A (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) None
Operation for Inguinal Hernia (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Home
DID AN OPERATION PRECEDE DEATH? yes DATE OF 6/2-30 (Herniotomy Inguinal)
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) W. A. Walters, M. D.
6/4, 1930 (Address) City Hosp #2

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Greenwood Cem. — DATE OF BURIAL 6/6 1930

20. UNDERTAKER C. H. Roberts — ADDRESS 2035 Lucas

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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