S. No. 2
—11-10-39
5-17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FEB 17 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 272

Registration District No. 1005 791 Primary Registration District No. Registrar's No. 272

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County 1

(b) City or town St Louis Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 4924 Labadie Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community 32 years 32

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St Louis 6
(If outside city or town limits write "RURAL")

(d) Street No. 4924 Labadie
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME KATHERINE FANNING

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex female

5. Color or race White

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased June (Month) 23 (Day) 1907 (Year)

8. AGE: Years 32 Months 6 Days 15 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)

10. Usual occupation Stenographer

11. Industry or business Wright Foot Appliance

MOTHER FATHER

12. Name Stephen L. Fanning

13. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)

14. Maiden name Hanna Shea

15. Birthplace St Louis (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Stephen Fanning

(b) Address 4924 Labadie Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 11 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Howard Son

(b) Address 4212 St Louis Ave

19. (a) JAN 10 1940 (Date received by local registrar) (b) J. B. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 8 year 1940 hour 9 15 minute A M.

21. I hereby certify that I attended the deceased from 1929 to , 19 , to Jan - 8 , 1940 that I last saw him alive on Jan 7 , 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Tuberculous pneumonia	4 days
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Charles Ellers (M. D. or other) M.D.

Address 7201 S Broadway Date signed 1-9-40

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Jos. A. Howard

Licensed Embalmer No. 4139

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.