

No. 2  
4-13-40  
-17-39  
I X23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
REC'D MAR 11 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

8187

Registration District No. 784

Primary Registration District No. 111

State File No. \_\_\_\_\_

Registrar's No. 356

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Richmond Heights

(c) Name of hospital or institution: St. Mary's Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Helen Fagan

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Single

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

7. Birth date of deceased Jan. 15 1910  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>31</u>	<u>1</u>	<u>0</u>	hr. _____ min. _____

9. Birthplace Springfield / Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Technician

11. Industry or business State Dep't. of Health

12. Name Thomas Fagan

13. Birthplace Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Katherine Mahoney

15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Leo Denny

(b) Address 4905 Maryland

17. (a) Removal (b) Date thereof 2/16/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springfield, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) FEB 16 1941 (b) D. R. Meyer  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County 999

(c) City or town Springfield  
(If outside city or town limits, write "RURAL")

(d) Street No. 4552 Vine  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 2 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 15  
year 1941 hour 5 minute 45 A.M.

21. I hereby certify that I attended the deceased from 11-25-40  
\_\_\_\_\_, 1940, to 2-15, 1941;

that I last saw her alive on 2-14, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Brain Tumor  
no medical aid

Due to \_\_\_\_\_

Due to 5-6-40

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations Tumor removed at operation.

Of autopsy None

Duration  
over 2 1/2 yrs

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Daniel L. Steffor (M. D. or other) M.D.

Address 607 North Grand Ave. Date signed 2-15-41

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

16  
1  
3

**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 *J. W. Binkley*.....

Licensed Embalmer No. *3653*.....

P. O. Address *St. Louis, Mo*.....

**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 this body is not embalmed, fact should be so stated above.**