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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUN 9 1943 318

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 4954

1. PLACE OF DEATH:

(a) County _____

(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:
Homer Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 days
(Specify whether years, months or days)

In this community 5 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

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

(d) Street No. 2340 Cole Street
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Dan Fant

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 5. Color or race Negro

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

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

7. Birth date of deceased March 6, 1886
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>2</u>	<u>4</u>	_____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation Odd Jobs

11. Industry or business _____

MOTHER FATHER {

12. Name Dan Fant

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

14. Maiden name Harriett Cochran

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

16. (a) Informant Shirley M. Smith
(b) Address 2601 N. Whittier

17. Washingon (Burial, cremation, or removal) Date thereof 5-13-43
(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) MAY 28 1943 (Date received local registrar)
J. F. Burdick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10,
year 1943 hour 12 minute 12 P. M.

21. I hereby certify that I attended the deceased from April 30, 1943 to May 10, 1943
that I last saw him alive on May 10, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death: Hypertension
Cerebral Hemorrhage

Duration
Unk.
1 week

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN

Major findings: _____
Of operations _____

Of autopsy _____

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 J. E. Smith (M. D. or other)
Address 2601 N. Whittier Date signed 5/12/43

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

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.....

Licensed Embalmer No.....

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