

142
S. No. 2
FORM-2-43
Rev. 5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40451

State File No. _____

FILED DEC 29 1943

Registration District No. **318**

Primary Registration District No. _____

Registrar's No. **11409**

1. PLACE OF DEATH:

(c) County St. Louis, Missouri

(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: St. Louis City Hospital
Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 Days
(Specify whether _____)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
17

(c) City or town St. Louis 923
(If outside city or town limits, write "RURAL")

(d) Street No. 1515 Lafayette Ave.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Fannie Roach

3. (b) If veteran, name war No 3. (c) Social Security No. 498-26-6301

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 November 17 1881
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>1</u>	<u>1</u>	_____ hr. _____ min.

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

10. Usual occupation Laundress

11. Industry or business Laundry City Hospital

12. Name Edward Roach

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

14. Maiden name Fannie Exshaw

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

16. (a) Informant Margaret Meyer

(b) Address 52260 Alpha Ave.

17. (a) Burial (b) Date thereof 12-21-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Cullinane Bros.

(b) Address 1710 N. Grand Blvd.

19. (a) DEC 20 1943 (b) J. J. Predeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 18, year 1943 hour 8:40 minute A. M.

21. I hereby certify that I attended the deceased from December 14, 1943, to December 18, 1943 that I last saw her alive on December 18, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy none

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 William J. Day (M. D. or other) _____
Address 1515 Lafayette Avenue Bk. 12/18/43

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

MOTHER FATHER

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

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.....

Fred Frick

Licensed Embalmer No. 3186

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.