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

1. PLACE OF DEATH: **ST LOUIS**

(a) County: _____
 (b) City or town: **RICHMOND HTS MO**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **17 DAYS ST MARYS HOSP**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **17 DAYS**
 In this community **2 YEARS**
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State: **Mo** (b) County: **000**
 (c) City or town: **ST LOUIS MO**
 (If outside city or town limits, write "RURAL")
 (d) Street No.: **5148 WELLS AVE**
 (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country: _____

3. (a) PRINT FULL NAME: **DELLA MAY FEGAN**

3. (b) If veteran, name war: **No** 3. (c) Social Security No.: **NONE**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: **Feb.** day: **23**
 year: **1944** hour: **2** minute: _____ P. M.

21. I hereby certify that I attended the deceased from **Feb. 12**
 19**44**, to **Feb. 23**, 19**44**
 that I last saw her alive on **Feb. 23**, 19**44**
 and that death occurred on the date and hour stated above.

4. Sex: **FEMALE** 5. Color or race: **W** 6. (a) Single, widowed, married, divorced: **MARRIED**

6. (b) Name of husband or wife: **THOMAS O. FEGAN** 6. (c) Age of husband or wife if alive: **46** years

7. Birth date of deceased: **JUNE 28 1895**
 (Month) (Day) (Year)

Immediate cause of death: **Tumor of Brain (Malignant)**

Due to: _____

Due to: _____

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

8. AGE: Years: **48** Months: **7** Days: **25** If less than one day: **13** hr. **25** min.

9. Birthplace: **CENTRAL CITY KENTUCKY**
 (City, town, or county) (State or foreign country)

10. Usual occupation: **HOUSEWIFE**

Major findings: Of operations: **Same**

Of autopsy: **Same**

PHYSICIAN: _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business: _____

12. Name: **THOMAS G WOODSON**

13. Birthplace: **CENTRAL CITY KENTUCKY**
 (City, town, or county) (State or foreign country)

14. Maiden name: **LULA BROWN**

15. Birthplace: **CENTRAL CITY KENTUCKY**
 (City, town, or county) (State or foreign country)

16. (a) Informant: **Thomas O. Fegan**
 (b) Address: **5148 Wells Ave**

17. (a) **BURIAL** (b) Date thereof: **FEB 26 1944**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **CALVARY CEM**

18. (a) Signature of funeral director: **Walter Dorkney**
 (b) Address: **6836 Clay Blvd**

19. (a) **FEB 25 1944** (b) **E. A. Mc Gowan, M.D.**
 (Date received local registrar) (Registrar's signature)

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 _____ Means of injury: _____

23. Signature: **[Signature]** (Name or other): **M.D.**
 Address: **4952 Maryland Ave** Date signed: **2/24/44**

5418 NPT

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 *Albert H. Jopp*
.....
Licensed Embalmer No. *1861*

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.