

FILED JUN 19 1944

State File No. _____

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

5121

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Isolation Hospital. 0
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5/28/44
 (Specify whether _____)
 In this community _____
 years, months or days to 6/3/44

3. (a) PRINT FULL NAME Clarence Fartner.

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

4. Sex Male 0
 5. Color or race White
 6. (a) Single, widowed, married, divorced 3

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

7. Birth date of deceased _____
 (Month) (Day) (Year) 1884

8. AGE: Years Months Days If less than one day
60 ? ? hr. min.

9. Birthplace PURVE | TENN.
 (City, town, or county) (State or foreign country)

10. Usual occupation MERCHANT11. Industry or business SELF

MOTHER FATHER {
 12. Name ? ?
 13. Birthplace ? ?
 (City, town, or county) (State or foreign country)
 14. Maiden name ? ?
 15. Birthplace ? ?
 (City, town, or county) (State or foreign country)

16. (a) Informant Stella Grady.(b) Address 5600 Arsenal St.

17. (a) Burial (b) Date thereof 6-5-44
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery18. (a) Signature of funeral director William A. Brown(b) Address 2504 Woodson Rd - Overland, Mo.

19. (a) JUN 5 1944 (b) J. F. Bedeak
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County 000
 (c) City or town St. Louis Mo. 13
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2813 Annapolis Overland. N.R.
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____ 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 3rd.
 year 1944 hour 3 minute 55 A M.

21. I hereby certify that I attended the deceased from 5/28
1944, 19____, to 6/3, 1944
 that I last saw him alive on 6/3, 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Meningitis, Acute
 Due to Meningococcus

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

Major findings: _____
 Of operations _____
 Of autopsy Meningitis, Multiple petechiae
 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 W. Klingberg (M. D. or other) _____
 Address 5600 Arsenal Date signed _____

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 W. L. Peterson
Licensed Embalmer No. # 3767
P. O. Address Overland

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.

FILED JUL 20 1948
State File No. _____
Registrar's No. 5121

Registration District No. 318

Primary Registration District No. 1003

State File No. _____

Registrar's No. 5121

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. James
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(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 Fortner

3. (a) PRINT FULL NAME Clarence J. Fortner

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Divorced

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

7. Birth date of deceased (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 60 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) J. F. Braddock (Registrar's signature)
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Day 14 Year 1948 Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER

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

3

19675