V. S. No. 2
00M—2-43
Rev. 5-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 8 1944

Registration District No. 318

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 26029

Registrar's No. 7594

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Peoples Hospital 0 (If not in hospital or institution, write street number or location)

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

In this community 22 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Missouri (b) County 17

(c) City or town St. Louis 911 (If outside city or town limits, write "RURAL")

(d) Street No. 3900 W. Belle PL (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Fannie Allen

3. (b) If veteran, name war —

3. (c) Social Security No.

4. Sex Female

5. Color or race Col

6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec (Month) 25th (Day) 1885 (Year)

8. AGE: Years 58 Months 8 Days 5 If less than one day hr. min.

9. Birthplace Charleston (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation House work

11. Industry or business

FATHER
12. Name Henderson Werley
13. Birthplace UNKNOWN (City, town, or county) Mo 0 (State or foreign country)

MOTHER
14. Maiden name Penney Avant
15. Birthplace UNKNOWN (City, town, or county) Mo 0 (State or foreign country)

16. (a) Informant Margaret Saunders

(b) Address 3900 W. Belle Pl Apt 5 D

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-5-44 (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director J.H. Randle & Son

(b) Address 3133 Bell ave

19. (a) SEP 1 1944 (Date received local registrar) (b) J F Biedeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 30, 1944

year hour 9:50 minute p M.

21. I hereby certify that I attended the deceased from 8/28/44, 19, to 8/30/44, 19;

that I last saw her alive on 8/30/44, 19;

and that death occurred on the date and hour stated above.

Immediate cause of death Ruptured aortic aneurysm - syphilitic

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy clinical

Duration

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address 3100a Lucas Date signed 9/1/44

544 (Licensed Embalmer's Statement on Reverse Side)

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 S. J. Watson

Licensed Embalmer No. 2698

P. O. Address 2769 Shoreline

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.