

FILED NOV 10 1944
 318

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **9193**

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: **St. Anthony Hospital** **0**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **3 Months**
(Specify whether
 In this community **Life**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____ **000**
 (c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL") **23**
 (d) Street No. **2739 A Magnolia Ave**
(If rural, give location)
 (e) Citizen of foreign country? _____ **0** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **ROSA FABICK**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**
 6. (b) Name of husband or wife **Philip Fabick** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Oct 16 1853**
(Month) (Day) (Year)

8. AGE: Years **01** Months **00** Days **12** If less than one day hr. _____ min. _____

9. Birthplace **St. Louis Mo.** **0**
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business **Housewife.**

12. Name **? Bartos**

13. Birthplace **Bohemia** **8**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Bohemia** **8**
(City, town, or county) (State or foreign country)

16. (a) Informant **Cecelia Fabick**

(b) Address **2739 A Magnolia Ave.**

17. (a) **Burial** (b) Date thereof **Oct 31/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Old S.S. Peter & Paul**

18. (a) Signature of funeral director **Thorndike & son**

(b) Address **8906 Gravois Ave.**

19. (a) **Oct 30 1944** (b) **J. J. Bredeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **28**
 year **1944** hour **7 40 A.M.** M.

21. I hereby certify that I attended the deceased from **May** 19**42** to **Oct. 28** 19**44**
 that I last saw her alive on **October 28** 19**44**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia Lobar**
hypostatic
 Due to **Chol. Dysentery**
Chol. Embocadent. mital
 Due to **Acute pyelonephritis**
Nephritis Glomerular
 Other conditions _____
(Include pregnancy within 3 months of death)

Duration

2 days

Major findings: **Stone 108**
 Of operations _____
 Of autopsy **none**

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) **no**
 (b) Date of occurrence **no**
 (c) Where did injury occur? **no**
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work **no** (Specify type of place) (e) Means of injury **no**

23. Signature **Joseph [unclear]** (M. D. or other) **MD**
 Address **2767 Gravois Ave** Date signed **10-30-44**

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

MOTHER FATHER

944

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 *David Lee Fossan*.....

Licensed Embalmer No. *4242*.....

P. O. Address *2906 Harris*.....

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.