

S. No. 2  
M-8-43  
5-17-39  
P. 1 X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36157

State File No. ....

FILED NOV 30 1944 318

1003

Registrar's No. 9891

Registration District No. ....

Primary Registration District No. ....

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

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(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:  
Homer G. Phillips Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 28 days  
(Specify whether)

In this community 65 years  
years, months or days

3. (a) PRINT FULL NAME Fannie McNeil

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 5. Color or race Colored

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

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased Oct. 11, 1879  
(Month) (Day) (Year)

8. AGE: Years 65 Months 1 Days 3 If less than one day hr. min.

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

10. Usual occupation Housework

11. Industry or business None

12. Name John Bruin

13. Birthplace None  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Williams

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

16. (a) Informant Joist Rollins

(b) Address 1514 N. Taylor

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-44  
(Month) (Day) (Year)

(c) Place: burial or cremation Washington Park, Sem.

18. (a) Signature of funeral director Capt. Nash

(b) Address NOV 15 1944

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 1514 N. Taylor  
(If rural, give location)

(e) Citizen of foreign country? None (Yes or No)  
None  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 17,  
year 1944 hour 5 minute 00 P. M.

21. I hereby certify that I attended the deceased from October 19, 1944 to November 17, 1944  
that I last saw her alive on November 17, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Cardio-vascular heart disease with cardiac failure Duration Unk.

Due to

Due to

Other conditions 92h  
(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) (Country) (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 [Signature] (M. D.)  
Address 2601 N. Webster Date signed 11/24/44

**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 C. J. Noah  
Licensed Embalmer No. 2432  
P. O. Address 111 N. 13th St.

**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.**