

S. No. 2  
DM-5-43  
v. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **15123**

**FILED MAY 21 1945**

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4068**

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
2757 Armand Place  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution no  
In this community 20 Years (Specify whether years, months or days)

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. 2757 Armand Pl.  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Nannie Lee Frail  
3. (b) If veteran, name war no 3. (c) Social Security No. no  
4. Sex Female 5. Color or race white  
6. (a) Single, widowed, married, divorced, Widowed  
6. (b) Name of husband or wife James Frail  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 3/11/1875  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Ma y 5 day 1945  
year 1945 hour 6 minute 00 P. M.  
21. I hereby certify that I attended the deceased from 3-20-45  
to 5-4-45, 1945  
that I last saw him alive on 5-4-45, 1945  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

8. AGE: Years 70 Months 1 Days 25  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Arteriosclerosis  
(Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace Montgomery W. Virginia  
(City, town, or county) (State or foreign country)

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?

10. Usual occupation Hous ewife  
11. Industry or business \_\_\_\_\_  
12. Name Arch Tucker  
13. Birthplace ? W. Virginia  
(City, town, or county) (State or foreign country)  
14. Maiden name Elipa Terry  
15. Birthplace ? Virginia  
(City, town, or county) (State or foreign country)

16. (a) Informant Blanch Harrah  
2757 Armand Pl.  
(b) Address Burial  
17. (a) (Burial, cremation, or removal) Burial (b) Date thereof 5/8/45  
(Month) (Day) (Year)  
(c) Place: burial or cremation New Pickers Cemetery

23. Signature Joseph L. Taylor (M. D. or other) 5/7-45  
Address 406 S. 50 Grand Date signed 5/7-45  
While at work? \_\_\_\_\_ (Specify type of place)  
(2) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director J. W. McLaughlin  
(b) Address 2301 Lafayette Ave.  
19. (a) May 7 1945 (b) J. F. Braddock  
(Date received local registrar) (Registrar's signature)

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

PC  
17  
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**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 *L.R. Cooper*.....

Licensed Embalmer No. *3633*.....

P. O. Address *2317 Lafayette*.....

**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.**