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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15279

State File No. \_\_\_\_\_  
Registrar's No. **4743**

**FILED JUN 9 1945**

Registration District No. **318**

Primary Registration District No. **1003**

**1. PLACE OF DEATH:**

(a) County \_\_\_\_\_

(b) City or town St. Louis, Missouri  
(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 11 days  
(Specify whether  
In this community 3 years  
years, months or days)

**3. (a) PRINT FULL NAME** Fannie Kidd

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race Negro

6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased: May 7 1889  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>56</u>	<u>0</u>	<u>16</u>	_____ hr. _____ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**

12. Name Unk.

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

14. Maiden name Unk.

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

16. (a) Informant Ora Littleton

(b) Address 1716 Glasgow

17. (a) Burial (b) Date thereof May 29 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Pk

18. (a) Signature of funeral director English Und. Co.

(b) Address 2931 Lida Ave.

19. (a) MAY 29 1945 J. F. Brudick  
(Date received by registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County 000

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

(d) Street No. 1716 Glasgow  
(If rural, give location) 20

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month May day 23,  
year 1945 hour \_\_\_\_\_ minute 40 A. M.

21. I hereby certify that I attended the deceased from May 12,  
1945 to May 23, 1945  
that I last saw her or alive on May 23, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Carcinoma of breast (left amputated)  
with metastasis

Duration Unk.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

50

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:

(c) 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 B. F. Murphy (M. D. or other) \_\_\_\_\_  
Address 2601 W. Ketchikan Date signed 5/24/45

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

**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 Burleson English

Licensed Embalmer No. 4208

P. O. Address 2931 Lucas, Ave

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. June  
Registrar's No. 4743

Registration District No. 218

Primary Registration District No. 1003

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:  
.....  
(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)

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.....

3. (a) PRINT FULL NAME Fannie Kidd

3. (b) If veteran, name war..... No.....

3. (c) Social Security No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 13  
year 1945 hour..... minute..... M.

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

4. Sex F

5. Color or race B

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

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

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

Immediate cause of death.....

Duration.....

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

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

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....

Of autopsy.....

10. Usual occupation.....

11. Industry or business.....

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)

PHYSICIAN.....

Underline the cause to which death should be charged statistically.

16. (a) Informant.....  
(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....  
(b) Address.....

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.....

19. (a) JUN 13 1945 (Date received local registrar)  
J. F. Breeseck (Registrar's signature)

23. Signature..... (M. D. or other)  
Address..... Date signed.....

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

SUPPLEMENTARY

15279