

FILED JUL 20 1945

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County.....  
(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:  
**Barnard Skin & Cancer Hospital**  
(If not in hospital or institution, write street number & location)  
(d) Length of stay: In hospital or institution.....  
(Specify whether  
In this community  
years, months or days)

3. (a) PRINT **Michael Joseph Fleming**  
FULL NAME ~~Joseph Fleming~~

3. (b) If veteran, name war **World War #1**  
3. (c) Social Security No. **498-16-8211**

4. Sex **male** 0  
5. Color or race **white**  
6. (a) Single, widowed, married, divorced **Divorced**

6. (b) Name of husband or wife **Ida Schaney**  
6. (c) Age of husband or wife if alive **51** years

7. Birth date of deceased **Sept. 23rd 1885**  
(Month) (Day) (Year)

8. AGE: Years **59** Months **9** Days **10**  
If less than one day  
hr. min.

9. Birthplace **Johns Town Penn.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Landscape Gardener**

11. Industry or business.....

12. Name **Patrick Fleming**

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

14. Maiden name **Mary Hebron**

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

16. (a) Informant **Mrs. Mary Ann McClane**  
(b) Address **7036 Winona Ave.**

17. (a) **burial** (b) Date thereof **7-6-45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cemetery**

18. (a) Signature of funeral director: **Jos. W. Clark**  
(b) Address **1125 Hodiamont Ave.**  
19. (a) **JUL 5 1945** (b) **J. F. Bredeck**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**  
(c) City or town **St. Louis** **17 5**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **5618 Etzel Ave.** **9**  
(If rural, give location)  
(e) Citizen of foreign country? **0** (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **2**  
year **1945** hour **8** minute **30 P.** M.

21. I hereby certify that I attended the deceased from **6-18-45**  
....., 19....., to **7-2-45**, 19.....;

that I last saw h. **in** alive on **7-2-45**, 19.....;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Respiratory failure** **10am**  
Duration

Due to **Post-operative condition**

Due to **Squamous carcinoma floor of mouth with cervical metastases**  
Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings: **Same as above**

Of operations.....  
Of autopsy **Not performed**

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?.....

(Specify type of place)  
While at work?..... (e) Means of injury.....

23. Signature **Walter R. Sattchick** (M. D. or other) **M. D.**  
Address **Barnard Skin & Cancer** Date signed **7-3-45**

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

50  
17  
9

MOTHER FATHER

**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..... *Jos. W. Clark*.....  
Licensed Embalmer No. *1641*.....  
P.O. Address *P.O. Linn, Mo.*.....

**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.**