

FILED JUL 20 1945

318

1008

Registration District No. _____ Primary Registration District No. _____

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 7 days
In this community 42 years
(Specify whether years, months or days)

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. 2611 Franklin
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Annie Flemings

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

4. Sex 7.3 5. Color or race Cal 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased September 10, 1905
(Month) (Day) (Year)

8. AGE: Years 39 Months 9 22 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business no

12. Name don't no

13. Birthplace don't no (City, town, or county) (State or foreign country)

14. Maiden name _____ 15. Birthplace don't no (City, town, or county) (State or foreign country)

16. (a) Informant Arden Jackson
(b) Address 2024 Cal St

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

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director _____
(b) Address 2809 Dayton

19. (a) JUL 7 1945 (Date received local registrar) D. F. Bredek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 2, year 1945 hour 6 minute 42 P. A. M.

21. I hereby certify that I attended the deceased from June 25, 1945, to July 2, 1945; that I last saw her alive on July 2, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Ca. of colon

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

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 _____

23. Signature B. F. Murphy (M. D. or other) _____
Address 2601 White Date signed 7/5/45

Duration Unk.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

00
17
9

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.....

Licensed Embalmer No. 2963

P. O. Address: 2915 Franklin

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.