

S. No. 2
OM-2-43
v. 5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29009

State File No.

Registrar's No.

7971

FILED SEP 21 1945
318

Primary Registration District No. 1003

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

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:
Desloge Hospital
(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)

3. (a) PRINT FULL NAME Thomas M. Fleming

3. (b) If veteran, name war None
3. (c) Social Security No. _____

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Widower

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

7. Birth date of deceased Dec. 25 1870
(Month) (Day) (Year)

8. AGE: Years 74 Months 8 Days 14
If less than one day hr. _____ min. _____

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

10. Usual occupation Retired

11. Industry or business Scruggs Vandervoort

12. Name Unknown Fleming

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

14. Maiden name Bridget Maher

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

16. (a) Informant Mrs. Charles Schiffhorst

(b) Address 3404 Rogers Pl.

17. (a) Burial (b) Date thereof 9 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

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

(b) Address 4228 So. Kingshighway Bl.

19. (a) SEP 12 1945 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 030
(c) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 3404 Rogers Pl.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sep't. day 9
year 1945 hour 2:40 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from 9/3
_____ 19____, to _____ 19____;

that I last saw him alive on 9/9 _____ 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

1. Cardio Renal vascular disease
2. Cirrhosis of the liver

Due to _____

Due to _____

Other conditions decreased lung service
(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 P. C. Lester (M. D. or other) U.D.

Address 3115 S. Grand Date signed 9/10

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

*Dr. Foster
3115 & Grand
2-5*

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 *Edwin D. Mc Dermott*

Licensed Embalmer No. *3024*

P. O. Address.....

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.