

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. **39126**
Registrar's No. **10607**

FILED DEC 21 1945
318

Registration District No. _____ 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**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Enroute to City Hospital 3
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Sarah G. Faller**
 3. (b) If veteran, name war **Nil**
 3. (c) Social Security No. **Unknown**

4. Sex **Female** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Widow**
 6. (b) Name of husband or wife **William Faller**
 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased **May 22 1864**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 6 13 hr. min.

9. Birthplace **Evansville Indiana 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business.....

12. Name **William Glynn**

13. Birthplace **Unknown Ireland 4**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Garvey**

15. Birthplace **Unknown Ireland 4**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mildred Long**

(b) Address **3736 Dunnica Ave.**

17. (a) **Burial** (b) Date thereof **12-8-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New St Peter & Paul**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Blvd.**

19. (a) **DEC 6 1945** **J. Z. Bradeck**
(Date received local registrar) (Registrar's signature)

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. **1113a Chestnut St.**
(If rural, give location)
 (e) Citizen of foreign country? **?** (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **5**
 year **1945** hour **1** minute **40** M.

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

Immediate cause of death.....
 Due to.....
 Due to.....
 Other conditions.....
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations.....
 Of autopsy.....

Duration.....
 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?.....

While at work?..... (Specify type of place)
 (e) Means of injury.....
 23. Signature **Dr. Royal J. [unclear]** (M. D. or other)
 Address **[unclear]** Date signed **11/6/45**

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..... *Henry M. Brammer*

Licensed Embalmer No..... *4200*

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.