

7. S. No. 2
OM-8-43
Ev. 5-17-39
X37823

DEPARTMENT OF COMMERCE

THE STATE BOARD OF HEALTH OF MISSOURI

BUREAU OF THE VITALS

STANDARD CERTIFICATE OF DEATH

FILED JUN 20 1946 318

State File No. 21982

Registrar's No. 5165

Registration District No. _____

Primary Registration District No. _____

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: JEWISH HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 24 1/2 HOURS
(Specify whether years, months or days) 6 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County 000
(c) City or town ST. LOUIS 777
(If outside city or town limits, write "RURAL")
(d) Street No. 4549^a DURANT 9
(If rural, give location) 0
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME LOIS JEAN MCFADIN

3. (b) If veteran, name war NO 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE 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 JANUARY 16 1940
(Month) (Day) (Year)

8. AGE: Years 6 Months 4 Days 3 If less than one day hr. _____ min. _____

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

10. Usual occupation NONE

11. Industry or business _____

12. Name VINCENT MCFADIN

13. Birthplace FT. GAGE ILL.
(City, town, or county) (State or foreign country)

14. Maiden name ELEANORE ANDERSON

15. Birthplace ST. LOUIS MO.
(City, town, or county) (State or foreign country)

16. (a) Informant VINCENT MCFADIN

(b) Address 4549^a DURANT

17. (a) BURIAL (b) Date thereof 6-11-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: ST. JOHN'S CE. 19

18. (a) Signature of funeral director: [Signature]
(b) Address 3934 N. 2nd St.

19. (a) JUN 10 1946 (Date received from registrar) J. F. Breuer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 9TH
year 1946 hour 12 minute 50^A 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: Stroke of the brain when she fell from brick wall of porch at home to concrete sidewalk about 5.00 P.M. June 9, 1946

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

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:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence June 9 1946

(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? Public place

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

23. Signature [Signature] (M. D. or other) 3
Address: _____ Date signed 6/10/46

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

2085

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 me

....., Registered Apprentice No.....
working under my personal supervision.

Signed A. G. Smithers

Licensed Embalmer No. 3916

P. O. Address 3934 N. 70 St

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.