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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAY 27 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 19549  
Registrar's No. 1831

Registration District No. 317 Primary Registration District No. 3063

1. PLACE OF DEATH:  
(a) County St. Louis County  
(b) City or town CLAYTON  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis County Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 1 mo. 13 da.  
(Specify whether  
In this community 7 yrs.  
years, months or days)

3. (a) PRINT FULL NAME FANNIE CRAMER  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex FEMALE 5. Color or race WHITE  
6. (a) Single, widowed, married, divorced WIDOWED  
6. (b) Name of husband or wife ROBERT 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased JUNE 17 1859  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>87</u>	<u>11</u>	<u>1</u>	_____ hr. _____ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business Housewife

12. Name FRANK WILSON

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

14. Maiden name MARY BERGER

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

16. (a) Informant E. E. CRAMER

(b) Address 3828 BOTANICAL, ST. LOUIS

17. (a) BURIAL (b) Date thereof 5-21-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Am. Burial Home

18. (a) Signature of Frank Wilson  
(b) Address 3809 S. Grand Blvd. No. 94

19. (a) 2-22-47 (b) Frank Wilson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Louis Co.  
(c) City or town JENNINGS 96  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2526 McHARRAN 0  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month MAY day 18  
year 1947 hour 9 minute 45 A. M.  
21. I hereby certify that I attended the deceased from APRIL 4, 1947, to MAY 18, 1947, and that I last saw her alive on MAY 18, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease & cardiac insufficiency and bronchopneumonia

Due to 107

Other conditions Subacute bacterial pneumonia of lung  
(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? \_\_\_\_\_

23. Signature Wm. C. H. W. M.D. (M. D. or other) \_\_\_\_\_  
Address 601 BRENTWOOD, Bldg. 2 Date signed 5/19/47

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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 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. †**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. JuneRegistrar's No. 1037Registration District No. 317Primary Registration District No. 3063

## 1. PLACE OF DEATH:

(a) County St Louis Co  
(b) City or town Clayton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(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 Fannie Cramer3. (b) If veteran,  
name war \_\_\_\_\_3. (c) Social Security  
No. \_\_\_\_\_4. Sex F5. Color W  
race \_\_\_\_\_6. (a) Single, widowed, married,  
divorced wid

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years7. Birth date of deceased June 17

(Month)

(Day)

(Year)

8. AGE:

Years 87Months 11Days 1

If less than one day

hr. \_\_\_\_\_ min.

9. Birthplace Ill

(City, town, or county)

(State or foreign country)

10. Usual occupation sewer

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_

year \_\_\_\_\_

hour \_\_\_\_\_

minute \_\_\_\_\_

M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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 sta-  
tistically.

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

S-19549