

No. 2
-1/47
5-17-39

FEDERAL BUREAU OF INVESTIGATION

National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **39628**
Registrar's No. **10361**

FILED NOV 22 1947

Registration District No. **318**

Primary Registration District No. **1003**

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
4534 Laclede Ave.
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County.....
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4534 Laclede Ave.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Margaret Ann Fargo**

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

4. Sex **1** **PF** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **W. 2**
6. (b) Name of husband or wife **Francis R. Frago** 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **March 10th., 1869**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	78	7	28 hr. min.

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

10. Usual occupation **At Home**

11. Industry or business.....
12. Name **Martin Berrigan**
13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
14. Maiden name **Bridget Chuurchill**
15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. A. J. Rost**
(b) Address **4534 Laclede Ave.**

17. (a) Burial **Sullivan, Mo.** (b) Date thereof **11-11-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Sullivan, Mo.**

18. (a) Signature of funeral director **Arthur J. Honnolly**
(b) Address **3840 Lindell Blvd.**

19. (a) **NOV 10 1947** (b) **J. P. B...**
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **8th.** year **1947** hour **8** minute **30 p.** M.

21. I hereby certify that I attended the deceased from **7-7-47** to **11-8-47**
that I last saw her alive on **11-8-47**
and that death occurred on the date and hour stated above. Duration

Immediate cause of death **Chronic myocarditis**
arteriosclerosis
chronic nephritis
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: **1/2/1**
Of operations.....
Of autopsy.....
Underline the cause of 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?..... (Specify type of injury)

23. Signature **W. H. ...** M. D. or other **MD**
Address **3803 N. ...** Date signed **11-10-47**

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

MOTHER FATHER

1 pm

P. 1000

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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.....

Stanley Marshall

Licensed Embalmer No. *2868*

P. O. Address *3840 Lindell*

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.