S. No. 2
I—1/47
. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

39634

State File No.

FILED DEC 6 1947

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10656

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: Homer G. Phillips Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)
In this community 32 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 6119 Pennsylvania (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME James Fennell
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male
5. Color or race Col
6. (a) ~~Single, widowed~~, married, ~~divorced~~ ~~Mark~~
6. (b) Name of husband or wife SARAH FENNELL
6. (c) Age of husband or wife if alive 80 years
7. Birth date of deceased JULY (Month) 10 (Day) 1887 (Year)

8. AGE: Years 59 Months 4 Days 16 If less than one day hr. min.

9. Birthplace TRINITY (City, town, or county) ALA. (State or foreign country)
10. Usual occupation LABORER
11. Industry or business LACLEDE GAS CO.
MOTHER FATHER
12. Name JACOB FENNELL
13. Birthplace UNKNOWN (City, town, or county) (State or foreign country)
14. Maiden name ERIE (UNKNOWN)
15. Birthplace UNKNOWN (City, town, or country) (State or foreign country)
16. (a) Informant Sarah Fennell
(b) Address 6119 PENNSYLVANIA
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-20-47 (Month) (Day) (Year)
(c) Place: burial or cremation WASHINGTON PARK CEM.
18. (a) Signature of funeral director J. E. Potter
(b) Address 3030 BELL AVE
19. (a) NOV 19 1947 (Date received local registrar) (b) J. F. Broncek (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 17 year 1947 hour 5 minute 25 A. M.
21. I hereby certify that I attended the deceased from Nov. 14, 1947 to Nov. 17, 1947 that I last saw him alive on Nov. 17, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis — Duration: Undet
Due to
Due to
Other conditions Hypertensive Heart Diseaase with Decompensation; Auricular Fibrillation
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy No

PHYSICIAN — 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 place)
While at work? (e) Means of injury
23. Signature Oscar L. Daniels (M. D. or other)
Address 2601 N Whittier Date signed 11/17/47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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 Esther A. Harris, Registered Apprentice No. 46, working under my personal supervision.

Signed W. Claude Gordon

Licensed Embalmer No. 34089

P. O. Address 4575 Aldine

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.