

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44191

FILED FEB 8 1952

State File No. _____
Registrar's No. 11011

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		State File No. _____		Registrar's No. <u>11011</u>					
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri.</u> b. COUNTY <u>St. Louis</u>									
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>			c. LENGTH OF STAY (in this place) <u>11 Days</u>			c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Webster Grove.</u>			60 <u>4207</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>1457 Grant Road.</u>									
3. NAME OF DECEASED (Type or Print) a. (First) <u>FERN N.</u> b. (Middle) <u>McKINNON</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 11 1951</u>										
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Sept 22, 1891</u>		9. AGE (In years last birthday) <u>60</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Colfax, Illinois</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13a. FATHER'S NAME <u>Robert Goodrich</u>				13b. MOTHER'S MAIDEN NAME <u>Frances Lackaye</u>			14. NAME OF HUSBAND OR WIFE <u>Charles P. McKinnon</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Chas P. McKinnon, 1457 Grant Road.</u>							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac Failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) starting the underlying cause last: DUE TO (b) <u>nephritis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Bronchopneumonia</u>								INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION.								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)								
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. HOW DID INJURY OCCUR? <u>593X</u>								
22. I hereby certify that I attended the deceased from <u>1 Dec., 1951</u> , to <u>11 Dec., 1951</u> , that I last saw the deceased alive on <u>10 Dec., 1951</u> , and that death occurred at <u>5:40 a. m.</u> , from the causes and on the date stated above.													
23a. SIGNATURE <u>John F. McCann M.D.</u>				23b. ADDRESS <u>St. John's Hospital</u>			23c. DATE SIGNED <u>12 Dec 51</u>						
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>Dec 13, 1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>			24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>						
DATE REC'D BY LOCAL REG. <u>DEC 12 1951</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Shepard Funeral Home, 1167 Hamilton Ave.</u>								

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Robert M. Murray

Licensed Embalmer No. *3749*

P. O. Address *St. Louis, Mo.*

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.