

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11522

State File No.

2974

Registrar's No.

FILED APR 4 1953

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis,		c. LENGTH OF STAY (in this place) 11 Weeks		c. CITY OR TOWN St. Johns	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or Print) a. (First) Virginia b. (Middle) Fancher c. (Last) Fancher			4. DATE OF DEATH (Month) (Day) (Year) March 16, 1953		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Married	8. DATE OF BIRTH 7-29-1905	9. AGE (In years last birthday) 47	IF UNDER 1 YEAR Months 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Table Worker		10b. KIND OF BUSINESS OR INDUSTRY Lennox Bag Co.		11. BIRTHPLACE (City and State or Foreign Country) Missouri	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME John W. Dixon		13b. MOTHER'S MAIDEN NAME Lucy Tripp	
14. NAME OF HUSBAND OR WIFE Farris Fancher		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 488-09-4601	
17. INFORMANT'S SIGNATURE OR NAME Farris Fancher		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Cancer of R+ Maxillary Sinus</i>		ADDRESS St. Johns, Mo	
19. INTERVAL BETWEEN ONSET AND DEATH 8 Mo		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 12/27 - 18 33, to 3/16 53, that I last saw the deceased alive on 3/16, 19 53 and that death occurred at 4:20 P. m., from the causes and on the date stated above.					
23a. SIGNATURE H.W. Nollen MD (Degree or title)		23b. ADDRESS 3720 W. Washington St. Louis		23c. DATE SIGNED 3/18/53	
24a. BURIAL (Specify)		24b. DATE 3-19-1953		24c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery	
24d. LOCATION (City, town, or county) St. Louis,		24e. (State) Missouri			
DATE REC'D BY LOCAL REG. MAR 18 1953		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McLaughlin's, 2301 Lafayette, St. Louis, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

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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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *James R. Chapman*.....
Licensed Embalmer No. *459*.....
P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.