

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9801**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town(ship)) OR TOWN St. Louis		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital		STREET ADDRESS (If rural, give location) 4763 Alma Ave. 20290	
3. NAME OF DECEASED (Type or Print) a. (First) ANNIE	b. (Middle) E.	c. (Last) FLEMING	4. DATE OF DEATH (Month) (Day) (Year) Oct. 27 1954
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH March 20, 1877
9. AGE (In years last birthday) 77		IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Jerseyville, Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME George England	
13b. MOTHER'S MAIDEN NAME Mary Costello		14. NAME OF HUSBAND OR WIFE Late John J. Fleming	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Florence Fleming 4763 Alma Ave.
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac failure INTERVAL BETWEEN ONSET AND DEATH ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Tuberc. Epidermoid Carcinoma 3 yrs. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION 11-10-51	19b. MAJOR FINDINGS OF OPERATION Epidermoid Carcinoma of Vagina.		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? 176X	
22. I hereby certify that I attended the deceased from 11-10-51 , 19 51 , to 10-27-54 , 19 54 , that I last saw the deceased alive on 10-27 , 19 54 , and that death occurred at 1:10A m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Wesley G. Charles, M.D.		23b. ADDRESS 4952 Maryland	23c. DATE SIGNED 10/28/54
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Oct. 29, 1954	24c. NAME OF CEMETERY OR CREMATORY St. Francis Cemetery	24d. LOCATION (City, town, or county) (State) Jerseyville, Ill.
DATE REC'D BY LOCAL REG. OCT 28 1954	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser 4228 S. Kingshighway Bl.	

S.P. (Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed *Richard W. Storey*

Licensed Embalmer No. *4000*

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