

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-045422

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11407 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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281207
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Infirmary

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Ill b. COUNTY St. Clair
c. CITY OR TOWN E. St. Louis
d. STREET ADDRESS (If outside, give location) 4 North 17th St.

3. NAME OF DECEASED First Middle Last Delores Amanda Cannon Fant
4. DATE OF DEATH Month Day Year Nov. 15, 1963

5. SEX Female 6. COLOR OR RACE Negro 7. Married Never Married Widowed Divorced
8. DATE OF BIRTH 2-11-1905 9. AGE (last birthday) 58

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (City and state or country) Altheimer, Arkansas
12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Doney Armstrong 13b. MOTHER'S MAIDEN NAME Betty Jones 14. NAME OF HUSBAND OR WIFE James Fant

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Thelma Enig 10 C John DeShields

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Peritonitis, Generalized, 8 weeks
DUE TO (b) Etiology undetermined
DUE TO (c) Hypertensive Cardiovascular Disease Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 578x
PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO
20a. ACCIDENT SUICIDE HOMICIDE
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1/30/63 to 11/12/63 and last saw her/him alive on 11/14/63
Death occurred at 2:15 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Chas R. Franz M.D. 22b. ADDRESS 1401 Gaty, E. St. L., Ill 22c. DATE SIGNED 11-18-63

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE 11-18-63 23c. NAME OF CEMETERY OR CREMATORY Boker Washington 23d. LOCATION (City, town, or county) Centerville, Ill (State)

24. FUNERAL DIRECTOR NASH FUNERAL HOME 111 N. 13th St. ADDRESS 25. DATE RECD. BY LOCAL REG. NOV 18 1963 26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

STATE OF TEXAS

DEPARTMENT OF HEALTH

CERTIFICATE

11-10-82

at the residence of

of the County of

State of Texas

at the residence of

of the County of

State of Texas

at the residence of

of the County of

State of Texas

OR 3

B

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 *M. James York*

Licensed Embalmer No. 4434

P. O. Address 111 W. 13th St.

82-85-11

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.