DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
AUG 11 1939

791

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24336

Registration District No. 1003 Primary Registration District No. Registrar's No. 6609

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: 1449 DeSoto Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 65 yrs.
years, months or days)

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. 1449 DeSoto Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 65 yrs. years.

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3. (a) PRINT FULL NAME Ida Fabian 150

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race W

6. (a) Single, widowed, married, divorced Wid.

6. (b) Name of husband or wife Henry Fabian

6. (c) Age of husband or wife if alive Decd. years

7. Birth date of deceased Aug. (Month) 15th. (Day) 1864 (Year)

8. AGE: Years 74 Months 11 Days 10 If less than one day hr. min.

9. Birthplace (City, town, or county) Germany (State or foreign country) 6

10. Usual occupation Housework 6

11. Industry or business

FATHER
12. Name Dont Know-Malicke 6
13. Birthplace (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Dont Know
15. Birthplace (City, town, or county) Germany (State or foreign country)

16. (a) Informant's own signature Otto A. Fabian
(b) Address 1449 DeSoto Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-28-39 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Provost Und Co
(b) Address 3710 N. Grand Blvd

19. (a) JUL 28 1939 (Date received local registrar) (b) J. F. Beldock (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 25th. year 1939 hour 7.00 minute P. M.

21. I hereby certify that I attended the deceased from 6/27, 1939, to 7/25, 1939
that I last saw her alive on 7/25, 1939,
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage (Apoplexy) — Duration 1 Ma.

Due to Arteriosclerosis Hypertension

Due to

Other conditions —
(Include pregnancy within 3 months of death)

Major findings:
Of operations —

Of autopsy —

PHYSICIAN
Underline the cause to 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 [signature] (M. D. or other)
Address 4901 N. Kingsbury Date signed 7/26/39

(Licensed Embalmer's Statement on Reverse Side)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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5a 4878

R. L. Byrd
4901 N. Broadway

10-12
3-4
7-8

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Robert L. Dunkman

Licensed Embalmer No. 3553

P. O. Address 3710 N Grand B

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, above space should be left blank.