

JAN 12 1940 791  
Registration District No. 1000

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St Louis  
(c) Name of hospital or institution: Homer G Phillips Hospital  
(d) Length of stay: In hospital or institution 16 days  
In this community Unknown

3. (a) PRINT FULL NAME Fannie Cooper  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. 160

4. Sex Female 5. Color or race Col  
6. (a) Single, widowed, married, divorced widow  
6. (b) Name of husband or wife unknown  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec 22 1875

8. AGE: Years 64 Months 0 Days 1  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Union mo.  
10. Usual occupation Housework  
11. Industry or business \_\_\_\_\_  
12. Name Dave Dewall  
13. Birthplace Union mo.  
14. Maiden name Sylvia Moore  
15. Birthplace Union mo.

16. (a) Informant's own signature Court Dewall  
(b) Address 1043 Eureka Place  
17. (a)  burial (b) Date thereof 12/23/39  
(c) Place: burial or cremation Washington Park  
18. (a) Signature of funeral director Mary Wade  
(b) Address 4302 Finley Ave  
19. (a) DEC 29 1939 (b) J. B. Beck

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St Louis  
(d) Street No. 1043 Eureka Place  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month December day 23  
year 1939 hour 1:00 minute 30 A. M.

21. I hereby certify that I attended the deceased from December 8, 1939, to December 23, 1939;  
that I last saw her alive on December 23, 1939,  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Arteriosclerotic Heart Disease  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 5 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Duration 3 das  
6-8 yrs  
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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_  
23. Signature H. J. Luman (M. D. or other) \_\_\_\_\_  
Address 2601 N Whitaker Date signed \_\_\_\_\_

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.

**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

*J. J. Watson*

Licensed Embalmer No.

*2698*

P. O. Address

*2769 Charlotte*

**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.**