

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. _____

954

Registrar's No. _____

954

Registration District No. 791

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: BARNES HOSPITAL
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10 days
 (Specify whether years, months or days) 17

3. (a) PRINT FULL NAME FRANCES FECKER LEVIS8. (b) If veteran, name war NONE 8. (c) Social Security No. NONE4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED6. (b) Name of husband or wife ARTHUR R. LEVIS 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased JAN. 27 1892
(Month) (Day) (Year)8. AGE: Years 48 Months — Days 2 If less than one day hr. _____ min. _____9. Birthplace CHICAGO ILLINOIS
(City, town, or country) (State or foreign country)10. Usual occupation HOUSEWIFE11. Industry or business OWN HOMEMOTHER FATHER { 12. Name ERNEST FECKER JR.13. Birthplace BROOKLYN NEW YORK
(City, town, or country) (State or foreign country)14. Maiden name CLARA SIMON15. Birthplace CHICAGO ILLINOIS
(City, town, or country) (State or foreign country)16. (a) Informant's own signature D. F. Burns(b) Address 1624 Central Ave. Alton Ill17. (a) BURIAL (b) Date thereof JAN. 31 1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation GRANDVIEW MAUSOLEUM, ALTON, ILL.18. (a) Signature of funeral director Robert H. Strecker(b) Address 2521 Edwards St. Alton Ill.19. (a) JAN 21 1940 (b) J. F. Bruch
(Date received local registrar) (Embalmer's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State ILLINOIS (b) County MADISON
 (c) City or town ALTON
 (If outside city or town limits, write "RURAL") NR
 (d) Street No. Box 241 - FAIRMOUNT DRIVE
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 29 year 1940 hour _____ minute 26 M.21. I hereby certify that I attended the deceased from JAN. 19, 1940, to JAN. 29, 1940;that I last saw her alive on JAN. 29, 1940, and that death occurred on the date and hour stated above.Immediate cause of death PULMONARY EMBOLISM
(non T.B.)

Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

PHYSICIAN _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature M. Anderson (M. D. or other) _____
Address BARNES HOSPITAL Date signed 1-29-40

SEP 30 1946

SEP 1 1946

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.....

Robert H. Streep....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Robert H. Streep*.....
Licensed Embalmer No..... *2474*.....
P. O. Address..... *Alton, Ill.*.....

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.