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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 13329

FILED MAY 15 1940

1003

Registration District No. 791

Primary Registration District No. _____

Registrar's No. 2534

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

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: City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

8. (a) PRINT FULL NAME Rosemary Fleeman 455

8. (b) If veteran, name war no 8. (c) Social Security No. no

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased November 20, 1937
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 4 27 hr. min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation at home 0

11. Industry or business _____

MOTHER FATHER { 12. Name Elzie Fleeman 1

18. Birthplace Frank Clay Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Rosie Hadlock

15. Birthplace Kaw City Okla.
(City, town, or county) (State or foreign country)

16. (a) Informant Elzie Fleeman

(b) Address 2231 S. 3rd St.

17. (a) Motorial (b) Date thereof 4/20/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leadwood Mo

18. (a) Signature of funeral director Weick Bros.

(b) Address 2201 S. Grand Ave.

19. APR 18 1940 (b) J. B. Bredebeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 23
(If outside city or town limits, write "RURAL")

(d) Street No. 2231 S. 3rd St.
(If rural, give location)

(e) If ~~buried~~ Physician _____ years
MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 17
year 1940 hour 1 minute 30 M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Sepsis (meningococci)

Due to _____

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? _____

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

23. Signature Joseph M. ... (M. D. or other) _____

Address Deputy ... Date signed _____

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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 *Samuel Stewart*.....

Licensed Embalmer No. 3722.....

P. O. Address. 412 Duchouquette.....

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 13329

Registration District No. 291 629

Primary Registration District No. 1003

Registrar's No. 3531

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. (Specify whether

In this community
years, months or days

3. (a) PRINT FULL NAME

Rosemary Fleeman 455

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased

(Month) (Day) (Year)

8. AGE:

Years 2 Months 4 Days 27
If less than one day hr min.

9. Birthplace

(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (b) Date thereof

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 5-23-40

(Date received local registrar)

(b) J. F. Bredeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits write "RURAL")

(d) Street No. (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 4-17 day 40
year hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19

that I last saw him alive on 19

and that death occurred on the date and hour stated above.

Immediate cause of death

Septicemia
Meningococci

Due to

Septicemia caused by
Meningococci
not localized

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

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?

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

23. Signature (M. D. or other)

Address Date signed

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

SUPPLEMENTARY

