FILED MAY 15 1940

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

13643

State File No.

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 3845

**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 6 hrs (Specify whether

In this community 22 yrs
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MISSOURI (b) County

(c) City or town ST. LOUIS 13
(If outside city or town limits, write "RURAL")

(d) Street No. 5509A MAGNOLIA AVENUE
(If rural, give location)

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

3. (a) PRINT FULL NAME Fleming - David 455

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Lillian

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

7. Birth date of deceased Sept. 3, 1862
(Month) (Day) (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 7 | 23 | hr. min. |

9. Birthplace Stony Point, N. C.
(City, town, or county) (State or foreign country)

10. Usual occupation Guard

11. Industry or business Art Museum

FATHER
12. Name Wm. Fleming
13. Birthplace Scotland
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Ann Bogard
15. Birthplace N. Carolina
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature [signature]
(b) Address 5509a Magnolia

17. (a) Burial (b) Date thereof 4/29/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Fillmore, Illinois

18. (a) Signature of funeral director [signature]
(b) Address 2301 Lafayette Ave

19. (a) APR 29 1940 (b) [signature]
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 26
year 1940 hour 5 minute 10 p.M.

21. I hereby certify that I attended the deceased from 4-26-40, 1940, to 4-26, 1940;
that I last saw him alive on 4-26, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Degenerative heart disease
Cardiac infarction
Multiple points of bleeding in G. I. tract
G-U tract & brain

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Coronary infarction
multiple bleeding areas

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

23. Signature [signature] (M. D. or other)
Address BARNES HOSPITAL Date signed 4/27/40

(Licensed Embalmer's Statement on Reverse Side)

7RB

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 L. R. Cadgeon

Licensed Embalmer No. ~~[illegible]~~ 363

P. O. Address 2301 Lafayette

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**