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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30310

Registration District No. 791 — Primary Registration District No. 1003 — Registrar's No. 7587

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Mo. Ave.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
2849 McNair Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis, Mo. 24
(If outside city or town limits write "RURAL")

(d) Street No. 2849 Mc. Nair Ave.
(If rural, give location)

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

3. (a) PRINT FULL NAME Mary Fellermann

3. (b) If veteran, name war No ½

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife William

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

7. Birth date of deceased About (Month) 1876 (Day) (Year)

8. AGE: Years About 64 Months Unknown Days If less than one day hr. min.

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

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name Joseph Loida
13. Birthplace (City, town, or county) Bohemia (State or foreign country)

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

16. (a) Informant Harry Fellermann
(b) Address 2849 McNair Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11-40 (Month) (Day) (Year)
(c) Place: burial or cremation New Picker

18. (a) Signature of funeral director [signature]
(b) Address 1926 Allen Ave.

19. (a) SEP 10 1940 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 8
year 1940 hour 5 minute 45 P. M.

21. I hereby certify that I attended the deceased from May 1 [illegible], 1940 to Sept. 8, 1940
that I last saw her alive on Sept 7, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic myocarditis	Centuries
Due to	
Due to arterio-sclerosis	[illegible]
Other conditions (Include pregnancy within 3 months of death)	

93C

Major findings:
Of operations none
Of autopsy none

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) no
(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? no
(Specify type of place)
While at work? (e) Means of injury

23. Signature [signature] (M. D. or other) M.D.
Address 3318 E. Grand Date signed Sept 9, 1940

(Licensed Embalmer's Statement on Reverse Side)

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 Benj C Duncan

Licensed Embalmer No. 2272

P. O. Address 1726 Allen

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.