

NOV 16 1940

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:
5904 Clemens Ave. 2
(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

Fanny Squire

3. (b) If veteran, name war No.

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 Joseph James Squire 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Sept. 5 1860
(Month) (Day) (Year)

8. AGE: Years 80 Months 1 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace England 4
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name James Thomas Nixon

13. Birthplace England 4
(City, town, or county) (State or foreign country)

14. Maiden name Esther Alcock

15. Birthplace England 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mable L. Squire

(b) Address 5904 Clemens Ave.

17. (a) Removal (b) Date thereof 10/7/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Caledonia, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. OCT 7 1940 (b) _____
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis 5
(If outside city or town limits, write "RURAL")
6
 (d) Street No. 5904 Clemens Ave.
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. 7th day 7th 1940 year. 10:30 hour 16 minute 30 P. M.

21. I hereby certify that I attended the deceased from May 5 1938 to October 7 1940;
 that I last saw her alive on October 7 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death Local peritonitis judicial 9-7-40
 Duration _____

Due to Emphysema of or rupture gall bladder from
 Due to cancer of same 6-9-40

Other conditions Arteriosclerosis years
(Include pregnancy within 3 months of death)

Major findings: Arteriosclerosis of proximal day
 Of operations None

Of autopsy None
 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 John W. Clark (M. D. or other) M.D.
 Address 824 N. Hamilton Blvd. Date signed 10-6-40

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

MOTHER FATHER

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.....

Ray W. Wilkerson

Licensed Embalmer No.....

3575

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.