

13-40
17-39
X23159

Registration District No. **791** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis**
(c) Name of hospital or institution: **1921 Oregon**
(d) Length of stay: In hospital or institution **none**
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(d) Street No. **1921 Oregon**
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **Laura Fahr**
(b) If veteran, name war **no**
(c) Social Security No. **no**

4. Sex **F** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **Single**
(b) Name of husband or wife _____ (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Unknown**
(Month) (Day) (Year)

8. AGE: Years **About 79** Months Days If less than one day
hr. min.

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

10. Usual occupation **Housework**

11. Industry or business _____

12. Name **Unknown**
13. Birthplace _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant **Dr. G. A. Hellman**
(b) Address **Shrewsbury, Missouri**

17. (a) **Cremation** (b) Date thereof **11-4-1940**
(c) Place: burial or cremation **Valhalla Crem.**

18. (a) Signature of funeral director **Jay B. Smith**
(b) Address **7456 Manchester**

19. (a) **NOV 4 1940** (b) *J. F. Puchner*
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **1**
year **1940** hour **8** minute **30 A.** M.
21. I hereby certify that I attended the deceased from **Oct - 1936**
to **Aug 5, 1940**

that I last saw her alive on **Oct 20, 1940**
and that death occurred on the date and hour stated above.
Immediate cause of death **Hypertension**

Cerebral Hemorrhage

Due to **April 1939 Slight**

Due to **Left hemiplegia**
did not fully recover

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 **Viola B. Sturmer** (M. D. or other) **S. D. O.**
Address **7310 Marquette Maplewood** Date signed **11/2/40**

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

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.....

J. A. Burgess

Licensed Embalmer No.....

4029

P. O. Address.....

Maplewood

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, fact should be so stated above.