

Registration District No. **784**

Primary Registration District No. **2nd**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Jefferson Barracks**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Veterans Administration Facility**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **Admitted 6/11/41**
(Specify whether years, months or days) **Since 6/11/41**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL") **12**
(d) Street No. **5609 Goethe**
(If rural, give location) **9**
(e) If foreign born, how long in U. S. A.? **-** years **1**

3. (a) PRINT FULL NAME **Julia S. Fabor**

3. (b) If veteran, name war **WORLD** 3. (c) Social Security No. **None**

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 **February 17 1874**
(Month) (Day) (Year)
8. AGE: Years **67** Months **4** Days **1** If less than one day **-** hr. **-** min.

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

10. Usual occupation **Nurse**

11. Industry or business **-**

MOTHER FATHER { 12. Name **Michael Fabor**
13. Birthplace **New York**
(City, town, or county) (State or foreign country)
14. Maiden name **Martha Peterson**
15. Birthplace **North Carolina**
(City, town, or county) (State or foreign country)

16. (a) Informant **M. Schuler**
(b) Address **Clinical Clerk, VAF, Jeff. Bks. Mo.**

17. (a) **REMOVAL** (b) Date thereof **6-19-41**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **BISMARCK, MO.**

18. (a) Signature of funeral director **D. R. Meyer, M.D.**
(b) Address **St. Louis, Mo. UND. CO.**

19. (a) **JUN 19 1941** (b) **D. R. Meyer, M.D.**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **18**
year **41** hour **7:10** minute **A.** M.

21. I hereby certify that I attended the deceased from **June 11**, 19**41** to **June 18**, 19**41**; that I last saw her alive on **June 18**, 19**41**; and that death occurred on the date and hour stated above.

Immediate cause of death **Aneurysm, cerebral portion, left, internal carotid artery, ruptured.** Duration **Unknown**

Due to **96**

Other conditions **-**
(Include pregnancy within 3 months of death)

Major findings: Of operations **None**

Of autopsy **Yes - See cause of death.**

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 **Chief Medical Officer** (Specify type of place) Means of injury **-**

23. Signature **C.W. HUGHES, M.D.** (M. D. or other) **0**
Address **Chief Medical Officer** Date signed **6/19/41**

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.....

Harry J. Schumacher

Licensed Embalmer No. 2679

P. O. Address 732 Zeman

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.