

FILED SEP 18 1944

Registration District No. 2571

Primary Registration District No. 3070

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

1. PLACE OF DEATH:

(a) County Saint Louis  
(b) City or town Webster Groves  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
17 Allison Street  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community Life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saint Louis  
(c) City or town Webster Groves 91.  
(If outside city or town limits, write "RURAL") 7  
(d) Street No. 17 Allison Street 7  
(If rural, give location) 7  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Fannie Mae Anderson

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. none

4. Sex Female

5. Color or race Negro

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

6. (b) Name of husband or wife John William Anderson alive \_\_\_\_\_ years

6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased Unavailable Abt. 1878  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
About 66 - - hr. min.

9. Birthplace Saint Louis, Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Tucker

13. Birthplace Unavailable, South Carolina (City, town, or county) (State or foreign country)

14. Maiden name Hannah Bowels

15. Birthplace Unavailable, South Carolina (City, town, or county) (State or foreign country)

16. (a) Informant Lucille Anderson

(b) Address 17 Allison Avenue

17. (a) Burial (b) Date thereof 9-9-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Father Dicksons Cem.

18. (a) Signature of funeral director Chas. J. Gates

(b) Address 4107 Finney Avenue

19. (a) SEP 9 - 1944 E. J. McManis M.D.  
(Date received) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September, 5th  
year 1944 hour 9 minute 45 p. M.

21. I hereby certify that I attended the deceased from 8/2/44 to 8/8/44  
that I last saw him alive on 8/5/44  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Coronary Thrombosis  
Due to Coronary Thrombosis

Due to Hypertension

Other conditions acute Dyspnea  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy Wright 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) (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 \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature E. J. McManis (M. D. or other) \_\_\_\_\_  
Address 643 E. Kirkham Ave. Date signed \_\_\_\_\_

JUL - 7 1950

AUG 15 1950

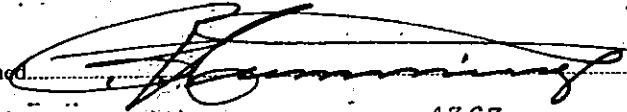
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Robert L. Cummings

Registered Apprentice No.....

working under my personal supervision.

Signed 

Licensed Embalmer No..... 4363

P. O. Address..... 4107 Finney Avenue

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.