

FILED APR 6 1945
Registration District No. 818

Primary Registration District No. 1003

Registrar's No. 2810

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

1. PLACE OF DEATH:

(a) County Missouri

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

(c) Name of hospital or institution:
Deaconess Hospital
(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 Fransos (unnamed)

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race wh. 6. (a) Single, widowed, married, divorced Infant

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

7. Birth date of deceased Feb: 19, 1945
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
				<u>2</u> hr. <u>45</u> min.

9. Birthplace St. Louis, Mo. _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Joseph Peter Fransos

13. Birthplace Normandy, Mo. _____
(City, town, or county) (State or foreign country)

14. Maiden name Edith Madeline Crocker

15. Birthplace Lyonn, Mass. _____
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. P. Fransos (Mother)

(b) Address 6504 Wadrow Ave.

17. (a) Burial (b) Date thereof 3-29-45
(Burial, cremation, or removal) (City or town) (County) (State) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of General Director V. B. Hudson

(b) Address City Health Dept

19. (a) 3-28-45 (b) J. F. Budeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

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

(d) Street No. 6504 Wadrow Ave.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 19
year 1945 hour 10 minute 15 P. M.

21. I hereby certify that I attended the deceased from 2-19-45
7:30 P. M. to 10:15 P. M.
that I last saw her alive on 2-19- _____, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 151

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: Of operations _____

Of autopsy _____

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) _____ (a) Means of injury _____

23. Signature Arnold S. Klein (M. D. or other) _____
Address 2637 S. Kingshighway Date signed 3/29/45

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.....

Licensed Embalmer No.....

P. O. Address.....

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.