

S. No. 2  
M-5-43  
7-5-17-39  
- 1 1906

**FILED SEP 1 1945**  
Registration District No. **318**

Primary Registration District No. **100**

Registrar's No. **7345**

**1. PLACE OF DEATH:**

(a) County.....

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

(c) Name of hospital or institution:  
Homer G. Phillips Hospital *D*  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mo. 28 days  
(Specify whether)

In this community 70 years  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County 066

(c) City or town St. Louis,  
(If outside city or town limits, write "RURAL") 17

(d) Street No. 3636 Page 9 11  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country.

**3. (a) PRINT FULL NAME** Fannie Oliver

**3. (b) If veteran,** name war.....

**3. (c) Social Security** No. none

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month August day 19,  
year 1945 hour 8 minute 20 P. M.

**21. I hereby certify that I attended the deceased from** June  
21, 1945 to August 19, 1945;  
that I last saw her alive on August 19, 1945;  
and that death occurred on the date and hour stated above.

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

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

**7. Birth date of deceased** June 6 1948  
(Month) (Day) (Year)

Immediate cause of death.....  
Senility

Due to..... Organic Brain Disease

Due to.....

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

Major findings:  
Of operations.....

Of autopsy.....

**Duration**  
Indef.

Unk.

**PHYSICIAN**  
87

Underline the cause to which death should be charged statistically.

**8. AGE:** Years Months Days If less than one day

97 2 13 .....hr. ....min.

**9. Birthplace** no  
(City, town, or county) (State or foreign country)

**10. Usual occupation** Teacher

**11. Industry or business**.....

**12. Name** Unknown

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

**14. Maiden name** Unknown

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

**16. (a) Informant** James H. Harrison

**(b) Address** 2906 Lawton

**17. (a) Washin Park** **(b) Date thereof** Aug 25, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** Washing Park

**18. (a) Signature of funeral director** James H. Harrison

**(b) Address** 2906 Lawton

**19. (a) AUG 23 1945** **(b) J. F. Butler**  
(Date received local registrar) (Registrar's signature)

**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?**.....  
(Specify type of place) **(e) Means of injury**.....

**23. Signature** H. J. Egan (M. D. wholistic)  
Address 2601 72 Date signed 8/30/45

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

0  
17  
9

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

*Arthur L. Hilliard*

Licensed Embalmer No. *4221*

P. O. Address *1154 Bayard*

**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.**