

FILED MAR 27 1946
318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3938a W. Florissant Ave /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
(Specify whether)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Florence M. Fairchild

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
7. Birth date of deceased: September 20, 1930
(Month) (Day) (Year)

8. AGE: Years 65 Months 5 If less than one day _____ hr. _____ min.

9. Birthplace Alton, Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Chambermaid

11. Industry or business _____

12. Name George Brenner

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

14. Maiden name Amelia Elbie

15. Birthplace Alton, Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Lorraine Brandon

(b) Address 7635 Rosedale Dr. Normandy

17. (a) Burial (b) Date thereof 3/16/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cemetery

18. (a) Signature of funeral director Math Hermann & Son

(b) Address 2161 East Fair Ave

19. (a) MAR 15 1946 (b) J. F. Bradock
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County W-00
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 2817
(d) Street No. 3938W Florissant Ave
(If rural, give location) 910
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 14,
year 1946 hour 9:30 PM minute _____ M.

21. I hereby certify that I attended the deceased from 9-14, 1940 to 3-14, 1946
that I last saw her alive on 3-11, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis - due Duration 6 yrs

Due to Hypertension

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy _____

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 W. H. Smith (M. D. or other) 2nd
Address 4800 Olive Date signed 3-14-46

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 *Gustav W. Dietrich*
Licensed Embalmer No. *4329*
P. O. Address *St. Louis, Mo*

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.

Registration District No. *918*

Primary Registration District No. *1003*

1. PLACE OF DEATH:

(a) County.....
 (b) City or town *St. Louis*
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
3938 e W. Florissant Ave
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution *none*
(Specify whether
 In this community.....
years, months or days)

3. (a) PRINT FULL NAME *Florence M. Fairchild*

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex *F* 5. Color or race *w* 6. (a) Single, widowed, married, divorced *wid*

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

7. Birth date of deceased *Sept 20 1880*
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 hr. min.

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

10. Usual occupation *Sanbernaes*

11. Industry or business.....

MOTHER FATHER { 12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar) (b) *J. A. J. Spence*
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
 (c) City or town.....
(If outside city or town limits, write "RURAL")
 (d) Street No.....
(If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Mar* Day *14*
 year *1946* hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....; that I last saw him..... after on....., 19.....; and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

Due to.....

Due to.....

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

Major findings:
 Of operations.....

Of autopsy.....

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.....

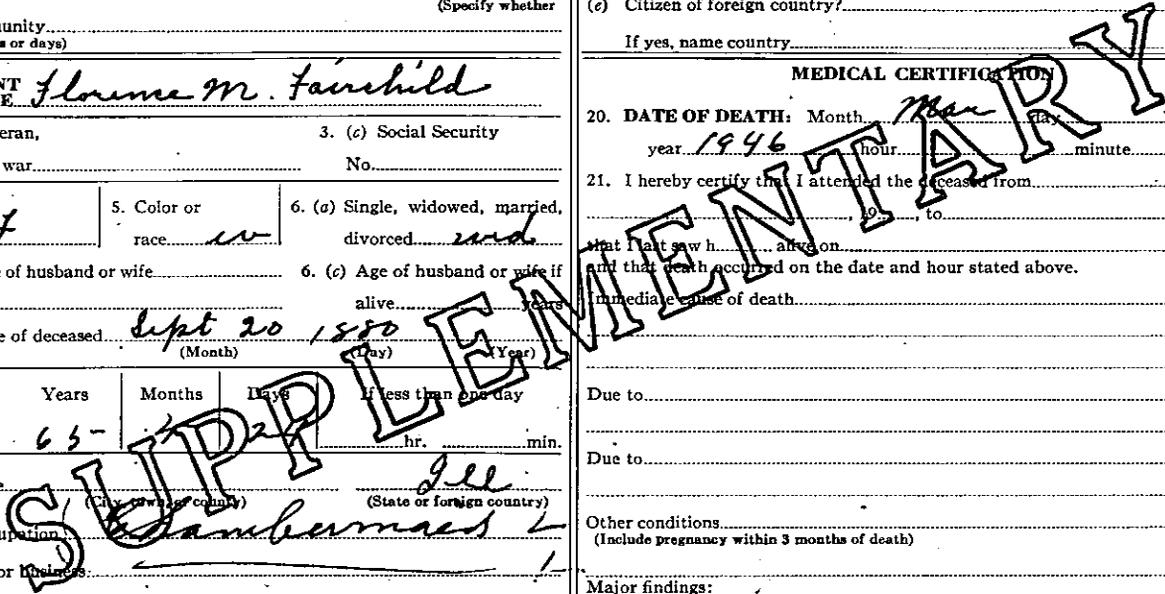
(c) Where did injury occur?.....
(City or town) (County) (State)

(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..... (M. D. or other).....

Address..... Date signed.....



USE ON REVERSE SIDE OF CARD

11093