S. No. 2
M—2-43
. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18933

FILED MAY 27 1946

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 1123

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 Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Since 4/10/46 (Specify whether
In this community 2 Months years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County Montgomery
(c) City or town Coffeen
(If outside city or town limits, write "RURAL")
(d) Street No. Box # 30
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME FEARS, Robert

3. (b) If veteran, name war World II

3. (c) Social Security No. Unknown

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married (Separated)

6. (b) Name of husband or wife Beulah Fears

6. (c) Age of husband or wife if alive 24 years

7. Birth date of deceased August (Month) 16 (Day) 1918 (Year)

8. AGE: Years 27 Months 9 Days 5 If less than one day hr. min.

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

10. Usual occupation Electro-plater

11. Industry or business

FATHER
12. Name Otis Fears
13. Birthplace Danville, Illinois (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Maude Short
15. Birthplace Springfield, Illinois (City, town, or county) (State or foreign country)

16. (a) Informant Clinical Clerk, Vet. Adm. Hosp.
(b) Address Jefferson Barracks, Missouri

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-22-46 (Month) (Day) (Year)
(c) Place: burial or cremation Decatur, Illinois

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) 5-24-46 (Date received local registrar) (b) [illegible] M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21 year 1946 hour 5:05 minute P M.

21. I hereby certify that I attended the deceased from 4/10/46, 19..., to 5/21/46, 19...; that I last saw him alive on May 21, 19 46 and that death occurred on the date and hour stated above.

Immediate cause of death PULMONARY INFARCT, MULTIPLE, BILATERAL, SECONDARY TO THROMBOPHLEBITIS; FEMORAL AND

Due to SAPHENOUS VEINS BILATERAL, CEPHALIC VEIN, LEFT, CAUSE UNDETERMINED — Duration: UNK

Due to

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations Vein Ligation 4-20-46
Caudal Injection 4-22-46
Of autopsy No 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) No
(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 L. E. STILWELL, M.D. (M. D. or other)
Address Vet. Adm. Hosp. Jeff. Brks., Mo. Date signed 5/22/46

(Licensed Embalmer's Statement on Reverse Side)

JUL 10 1946

MAY 18 1950

OCT 27 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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed John A. Ogonoski

Licensed Embalmer No. 3398

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.