

S. No. 2
M-543
v. 5-17-39
I X3667

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED 1946
#01411 318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

28632
State File No. _____
Registrar's No. 7317

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County St. Louis, Missouri.
(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:
St. Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 DAYS
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME JOHN FENLON
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb 1 1869
February 1, 1869 (Month) (Day) (Year)

8. AGE: Years 77 Months 6 Days 20
If less than one day hr. _____ min. _____

9. Birthplace St Louis MO (City, town, or county) (State or foreign country)
10. Usual occupation GROCERY CLERK
11. Industry or business _____
12. Name WM. FENLON
13. Birthplace IRELAND (City, town, or county) (State or foreign country)
14. Maiden name MARY ROACH
15. Birthplace IRELAND (City, town, or county) (State or foreign country)

16. (a) Informant Ester Hertzog
(b) Address 5370 Maple
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG 24 1946 (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY
18. (a) Signature of funeral director Cybil Kelly
(b) Address 4386 Grand
19. (a) AUG 23 1946 (Date received local registrar) (b) J. T. Bradock (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County 000
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 5600 EASTON Memorial (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug. day 21st
year 1946 hour 5:55 minute A M.
21. I hereby certify that I attended the deceased from 8/13/46
19____ to Aug. 21st 1946
that I last saw him alive on Aug. 21st 1946
and that death occurred on the date and hour stated above.

Duration _____
Immediate cause of death Coronary occlusion
Due to Arteriosclerotic Cardiovascular disease, generalized, advanced. years _____
Due to _____

Other conditions Acute coronary infarction for 2 days
(Include pregnancy within 3 months of death)
Probable, pending autopsy with medicines
Major findings: Of operations _____
Of autopsy 92
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 9
23. Signature Joseph P. Vafayette 1515 Lafayette 8/22/46 (Date signed or other)
Address _____ Date signed _____

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

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 James A. Linness

Licensed Embalmer No. 4142

P. O. Address St. Louis

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.