

U.S. No. 2  
DOM-5-43  
Rev. 5-17-39  
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32484

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED OCT 4 1947  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9085**

1. PLACE OF DEATH:

(a) County St. Louis Mo.

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

(c) Name of hospital or institution:  
Missouri Baptist Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County \_\_\_\_\_ 96

(c) City or town Robertson 0  
(If outside city or town limits, write "RURAL") 0

(d) Street No. RR 1 - Box 585 1  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Infant Fanni

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 14  
year 1947 hour 3 minute 45 P.M.

4. Sex Boy 5. Color or race white

6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased Sept. 14 1947  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept. 14 1947 to Sept. 14 1947  
that I last saw him alive on Sept. 14 1947  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
7 hr. 32 min.

Immediate cause of death unknown  
Premature birth at 6 mo.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) 15 ft

9. Birthplace St. Louis Mo 0  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Joseph Anthony Fann

13. Birthplace St. Louis Mo. (State or foreign country)

14. Maiden name Neoma Ruth Jennings

15. Birthplace Bonne Terre Mo. (State or foreign country)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

16. (a) Informant Missouri Baptist Hosp  
(b) Address 919 N. Taylor

17. (a) Anatomical Board (b) Date thereof 9-18-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springfield

18. (a) Signature of funeral director Edwin H. Smith  
(b) Address 3500 Rutledge

19. (a) SEP 30 1947 (b) J. F. Redback  
(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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 0

23. Signature Edwin H. Smith (M. D. or other) 142  
Address 701 - Olive St Date signed 9-17-47

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

MOTHER FATHER

No - 48-0110

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**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.**