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FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
FILED JUL 27 1948

U.S. DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

23353

State File No. _____

Registration District No. 160

Primary Registration District No. 3029

Registrar's No. 54

1. PLACE OF DEATH:
(a) County Jefferson
(b) City or town Crystal City
(c) Name of hospital or institution: ✓
(d) Length of stay: In hospital or institution ✓
In this community 74 years (Specify whether years, months or days)

3: (a) PRINT FULL NAME Fannie Solomon
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓

4. Sex Female 5. Color or race colored
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Johnson
6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased Nov. 23, 1873 (Month) (Day) (Year)

8. AGE: Years 74 Months 7 Days 14 If less than one day hr. min.

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

10. Usual occupation Housework

11. Industry or business own home

12. Name Don Streetcy

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

14. Maiden name Mary Fisher

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

16. (a) Informant Mr. Johnson Solomon

(b) Address Crystal City, Mo.

17. (a) Burial (b) Date thereof July 19, 1948 (City or town) (County) (State)

(c) Place: burial or cremation Crystal City, Mo.

18. (a) Signature of funeral director [Signature]
(b) Address Crystal City, Mo.

19. (a) July 9, 1948 (b) [Signature] (Date of civil local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jefferson
(c) City or town Crystal City
(d) Street No. 144 Lincoln St.
(e) Citizen of foreign country? (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7 year 1948 hour 8 minute 45 A.M.
21. I hereby certify that I attended the deceased from Jan 1 to July 7, 1948 that I last saw her alive on July 6th, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis with Valvular Insufficiency and Chronic Bronchial Asthma
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations [Signature]
Of autopsy [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?

23. Signature [Signature] (M. D. or other) Address [Signature] Date signed [Signature]

Duration Unknown
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed JUL 26 1948

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 *Henry R. Salter*

Licensed Embalmer No. *3486*

P. O. Address *Crystal City*

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.