

No. 300
-10-47
-17-39
PI 3906

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. 38088
Registrar's No. 9761

FILED NOV 21 1948 318
Registration District No. 318

Primary Registration District No. 1003

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

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: HOMER G. PHILLIPS
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME John Nevil Faen

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex MALE 5. Color or race Col

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

6. (b) Name of husband or wife SADIE FAEN

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased: MAR 19 1900
(Month) (Day) (Year)

8. AGE: Years 48 Months 7 Days 219 hr. _____ min. _____

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

10. Usual occupation LABOR

11. Industry or business _____

12. Name CLAUDE FAEN

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

14. Maiden name CORNELIA McLEOD

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

16. (a) Informant SHADIE FAEN

(b) Address 2819 BERNARD

17. (a) SHIPPED (b) Date thereof 11-13-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MAZON MISSISSIPPI

18. (a) Signature of funeral director F. A. GREEN

(b) Address 4214 D. B. MAR

19. (a) NOV 10 1948 (b) J. B. Casater
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County ST. LOUIS

(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")

(d) Street No. 2819 BERNARD
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 8
year 1948 hour 3:10 minute P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h_____ alive on _____, 19____;

and that death occurred on the _____ date and hour stated above.

Immediate cause of death Stab wound of chest and subclavian artery inflicted with butcher knife during a struggle in the truck at the southwest corner of Harrison & Market St around 3:10 P.M.

Other conditions Nov. 8, 1948
(Include pregnancy within 8 months of death)

Major findings: 168

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged etiologically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Justifiable Homicide

(b) Date of occurrence Nov. 8, 1948

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

(d) Did injury occur in or about home, on farm, in industrial place, in public place? In Public Place
(Specify type of place)

While at work? no (Specify type of place) (Specify type of place)

Means of injury see above

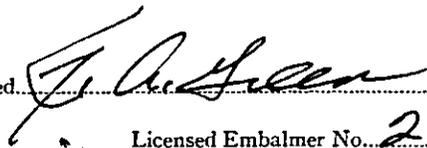
23. Signature W. Perry (M. D. or other) _____
Address 1818 Horner Date signed 11/10/48

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. 2963

P. O. Address 4214 DELMAR

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.