

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19463**

Registrar's No. **4914**

FILED JUN 7 1957

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived; If institution, residence before admission). a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2824 Clark ave.		e. STREET ADDRESS (If rural, give location) 2824 Clark ave.	
3. NAME OF DECEASED (Type or Print) a. (First) FANNIE b. (Middle) WILSON c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) May 23, 1957	
5. SEX FEMALE		6. COLOR OR RACE Col	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH April 10, 1860	
9. AGE (In years last birthday) 97		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil	
11. BIRTHPLACE (City and State or Foreign Country) Miss		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME PERRY BEBENS		13b. MOTHER'S MAIDEN NAME DENNA BEBENS	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME John Davis 2824 Clark	
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c) Hypertensive Cardiovascular Disease		19. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (b) _____ DUE TO (c) _____	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. ACCIDENT SUICIDE HOMICIDE (Specify)	
21a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 1	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from 10/30 , 19 56 , to 5/23 , 19 57 , that I last saw the deceased alive on 5/22 , 19 57 , and that death occurred at 2 P m., from the causes and on the date stated above.	
23a. SIGNATURE L R Wentzel MD (Degree or title)		23b. ADDRESS 2726 Chouteau	
23c. DATE SIGNED 5/24/57		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE May 27/57		24c. NAME OF CEMETERY OR CREMATORY Gal. Dale Cem	
24d. LOCATION (City, town, or county) (State) St Louis Mo		25. FUNERAL DIRECTOR'S SIGNATURE Carl Smith MD	
DATE REC'D BY LOCAL REG. MAY 25 '57		ADDRESS F. A. Green 4214 Delmar	

(Licensed Embalmer's Statement on Reverse Side)

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

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, Student Embalmer No. working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed..... *F. A. Green*

Licensed Embalmer No. *296*

P. O. Address *4214 Delma*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.