

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state

8 - 1939

REC'D MAY 10 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

16129  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Madison Registration District No. 784  
 (b) Township Richmond Heights Primary Registration District No. 111 Registered No. 638  
 (c) City Richmond Heights (d) Street No. St. Marys Hospital St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Jane T. Frank.  
 (a) Residence, No. 7019 Stanley Ave. St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF George R. Frank.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 27-1863

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
<u>76</u>	<u>10</u>	<u>10</u>	<u>10</u>	

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York

FATHER  
 13. NAME James A. Powers.  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

MOTHER  
 15. MAIDEN NAME Jane Kinsella.  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

17. INFORMANT Mr. Oscar B. Kline.  
 (ADDRESS) 1069 McCausland Ave.

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Calvary DATE Apr. 10, 1939.

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Arthur J. Donnelly.  
3840 Lindell Blvd

20. FILED APR 8 - 1939 St. Marys Hospital Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 7, 1939

22. I HEREBY CERTIFY, That I attended deceased from Mar 17<sup>th</sup> 1939, to April 7<sup>th</sup> 1939  
 I last saw her alive on Apr 7<sup>th</sup> 1939. Death is said to have occurred on the date stated above, at 7:50 A.M.  
 The principal cause of death and related causes of importance were as follows:  
Chronic Myocarditic and Cardiac Failure with congestion  
932  
 Date of onset 3 weeks ago

Other contributory causes of importance:  
Arteriosclerosis with hypertension

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify \_\_\_\_\_ (Signed) R. Brent Murphy, M. D.  
 (Address) 6120 Victoria Ave

6120  
1-3  
Mortimer

**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 Stanley Marchlewski

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**