

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(c) Name of hospital or institution: 906 Chambers St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME Frank Meixner
3. (b) If veteran, name war World War 3. (c) Social Security No. Unknown

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 14, 1897
(Month) (Day) (Year)

8. AGE: Years 42 Months 8 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace Shanka, Austria
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Concrete

12. Name Unknown
13. Birthplace Unknown (State or foreign country)

14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Helen Belman
(b) Address 906 Chambers St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/39 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director A. W. McLaughlin
(b) Address 2301 Lafayette Ave

19. (a) DEC 27 1939 (Date of local registrar) (b) _____ (Signature of local registrar)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis 26
(If outside city or town limits, write "RURAL")
(d) Street No. 906 Chambers St (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 25
year 1939 hour 10 minutes 20 P. M.

21. I hereby certify that I attended the deceased from 12-25-, 1939, to 12-28-, 1939;
that I last saw him alive on 12-28-, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of stomach
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

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

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 _____
23. Signature H. P. Kessler (M. D. or other)
Address 1943 W 114 St Date signed 12-27-39

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 Paul A Keith
Licensed Embalmer No. 3617
P. O. Address 2317 Lafayette

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, above space should be left blank.