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7-39
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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED AUG 28 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 23378

Registration District No. 791

Primary Registration District No.

Registrar's No. 5730

1. PLACE OF DEATH:

(a) County _____

(b) City or town **St. Louis**

(c) Name of hospital or institution: **5535 Pershing Blvd.**
(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 **Isadore Nathan Frank**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **Male**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Ethel Mary Frank**

6. (c) Age of husband or wife if alive **55** years

7. Birth date of deceased **March 7 1869**
(Month) (Day) (Year)

8. AGE: Years **72** Months **6** Days **3** If less than one day hr. min.

9. Birthplace **Evansville Indiana**
(City, town, or county) (State or foreign country)

10. Usual occupation **Tailor**

11. Industry or business _____

12. Name **Nathan Frank**

13. Birthplace **Germany** 4
(City, town, or county) (State or foreign country)

14. Maiden name **Theresa Unknown**

15. Birthplace **Germany** 4
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Ethel Frank**

(b) Address **5535 Pershing Ave.**

17. (a) **Cremation** (b) Date thereof **7B 14-1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Valhalla Crematory**

18. (a) Signature of funeral director **[Signature]**

(b) Address **5216 Delmar Bldg.**

19. (a) **JUL 11 1941** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **5535 Pershing Ave.**
(If rural, give location)

(e) If foreign born, how long in U. S. A.? **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **10** year **1941** hour **4** minute **40 P.** M.

21. I hereby certify that I attended the deceased from **Nov 75**, 19**40** to **July 10**, 19**41**
that I last saw him alive on **July 9**, 19**41**
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to **Chronic of Retinitis & mo**

Due to **Diamond Fluxure**

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: **HL**

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 **[Signature]** (M.D. or other) **0**

Address **5022 Page** Date signed **7-10-41**

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

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9

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17
129

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.....

Chas W. Cooper

Licensed Embalmer No. *3850*

P. O. Address *5216 Delmar*

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

If this body is not embalmed, fact should be so stated above.