S. No. 2
M. 5-43
5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 26 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15124

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4394

1. PLACE OF DEATH:

(a) County ST. LOUIS MO
(b) City or town (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution ISOLATION HOSPITAL (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4-24-45-5-16-45 (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County
(c) City or town ST LOUIS (If outside city or town limits, write "RURAL") 13
(d) Street No. 5800 ARSENAL (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME HARRY FRANCK

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 SINGLE
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July (Month) 20th (Day) 1867 (Year)

8. AGE: Years 77 Months 9 Days 26 If less than one day hr. min.

9. Birthplace MISSOURI (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name CHARLES FRANCK
13. Birthplace (City, town, or county) GERMANY (State or foreign country)
MOTHER
14. Maiden name SOPHIA BRUED
15. Birthplace (City, town, or county) GERMANY (State or foreign country)
16. (a) Informant NELLIE HARRIS
(b) Address 5600 Arsenal
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof MAY 18 '45 (Month) (Day) (Year)
(c) Place: burial or cremation St. Peters Cem.
18. (a) Signature of funeral director Drehmann-Hamm
(b) Address 1905 Union Blvd.
19. (a) MAY 18 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5-16-45 day year hour 9 minute 45P M.
21. I hereby certify that I attended the deceased from 4-24-45 5-16-45, 19 to , 19 ; that I last saw him alive on 5-16-45, 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) Degenerative heart disease

Major findings: Of operations

Of autopsy

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature J. W. Maxwell (M. D. or other)
Address 5600 Arsenal St. Date signed 5-17

(Licensed Embalmer's Statement on Reverse Side)

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 Albert A. Thompson

Licensed Embalmer No. 4237

P. O. Address St. Louis

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.

S. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June 4

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 639

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Harry Franck

3. (b) If veteran, name war

3. (c) Social Security No.

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 July (Month) 20 (Day) 1856 (Year)

8. AGE: Years 77 Months Days 28 If less than one day hr. min.

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

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) JUN 4 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute M.

21. I hereby certify that I attended the deceased from , to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

15124