

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2450

State File No.

FILED JAN 29 1952

BIRTH NO. _____		REG. DIST. NO. <u>310</u>		PRIMARY REG. DIST. NO. <u>3058</u>		Registrar's No. <u>13</u>			
1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Charles</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Charles</u>		c. LENGTH OF STAY (in this place) <u>2 1/2 hrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>O'Fallon</u>		<u>0920</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>/</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Frank</u> b. (Middle) <u>W.</u> c. (Last) <u>Schwane</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 17 1952</u>						
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 24 1887</u>		9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>O'Fallon Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Adolph Schwane</u>			13b. MOTHER'S MAIDEN NAME <u>Stinger</u>			14. NAME OF HUSBAND OR WIFE <u>Cecelia Schwane</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>498-18-8336</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Arthur Schwane</u>			ADDRESS <u>O'Fallon Mo</u>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Ruptured myocardium ducts</u> <u>myomalacia cordis</u> <u>cardiac infarction</u> DUE TO (b) <u>Coronary arteriosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS: <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		<u>4200</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			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 <u>Jan 16, 1952</u> , to <u>Jan 17, 1952</u> , that I last saw the deceased alive on <u>Jan 17, 1952</u> , and that death occurred at <u>9:45 A.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>George R. Saxathi MD</u> (Degree or title)				23b. ADDRESS <u>O'Fallon Mo.</u>			23c. DATE SIGNED <u>1/19/52</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Jan. 21 '52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Assumption Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>O'Fallon MO</u>				
DATE REC'D BY LOCAL REG. <u>Jan 21-52</u>		REGISTRAR'S SIGNATURE <u>Francis Hamilton</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Earl Keithly</u>		ADDRESS <u>O'Fallon MO</u>		

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

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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

Student Embalmer

Signed _____

E. K. Keithly

Licensed Embalmer No. 822

P. O. Address O'Fallon Mo.

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.