

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2798**
Registrar's No. **0712**

FILED FEB 14 1952

REG. DIST. NO. **310**

PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY	
b. CITY OR TOWN ST LOUIS	c. LENGTH OF STAY (in this place) 17 YEARS	c. CITY OR TOWN ST LOUIS	219
d. FULL NAME OF HOSPITAL OR INSTITUTION STATE HOSPITAL 5400 ARSENAL		d. STREET ADDRESS (If rural, give location) 1311 N. TAYLOR AVE	
3. NAME OF DECEASED (Type or Print)	a. (First) DOMINIC	b. (Middle) B.	c. (Last) FRAIN
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH JUNE 22, 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOKKEEPER (Retired)	10b. KIND OF BUSINESS OR INDUSTRY FUR PROCESSING CO.	11. BIRTHPLACE (State or foreign country) ST LOUIS MO	12. COUNTRY OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME JAMES J. FRAIN	13b. MOTHER'S MAIDEN NAME KATHERINE COFFEY	14. NAME OF HUSBAND OR WIFE ANNE DAVIS FRAIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME D. JAMES FRAIN ADDRESS 1404 BERGER PL.	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia		INTERVAL BETWEEN ONSET AND DEATH 5 days	
ANTECEDENT CAUSES		DUE TO (b) Nephritis	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	
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? 593 X	
22. I hereby certify that I attended the deceased from Jan 8, 1940 , to Jan 22, 1952 , that I last saw the deceased alive on Jan 22, 1952 , and that death occurred at 9:40 AM. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Paul T. Hartman M.D.		23b. ADDRESS 5400 Arsenal Street	23c. DATE SIGNED 1/22/52
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE JAN 25, 1952	24c. NAME OF CEMETERY OR CREMATORY CALVARY	24d. LOCATION (City, town, or county) (State) ST LOUIS MO
DATE REC'D BY LOCAL REG. JAN 23 1952	REGISTRAR'S SIGNATURE Paul Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Cullen Kelly 4386 LINDELL BLVD.	

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

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

Paul Wolfman

Licensed Embalmer No. 4366

P. O. Address St Louis, 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.