

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10540

State File No.

FILED MAR 22 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1896**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. LENGTH OF STAY (in this place) 10yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis 2149		
d. FULL NAME OF HOSPITAL OR INSTITUTION 5841 Devonshire			d. STREET ADDRESS (If rural, give location) 14 5841 Devonshire		

3. NAME OF DECEASED (Type or Print) a. (First) Frances		b. (Middle)		c. (Last) Sauter		4. DATE OF DEATH (Month) (Day) (Year) Feb 26, 1952			
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single		8. DATE OF BIRTH Nov 21, 1865		9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St Louis Mo		12. CITIZEN OF WHAT COUNTRY? USA		

13a. FATHER'S NAME Severin Sauter		13b. MOTHER'S MAIDEN NAME Doretta Koch		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Frances K Jones 5841 Devonshire	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Valvular Heart disease				INTERVAL BETWEEN ONSET AND DEATH ?	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death. Eczematoid dermatitis				> 90.	
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) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 421.4	

22. I hereby certify that I attended the deceased from **June, 1950**, to **Feb 26, 1952**, that I last saw the deceased alive on **Feb 18, 1952**, and that death occurred at **2:00 A m.**, from the causes and on the date stated above.

23a. SIGNATURE (Name or title) Carl H Klein		23b. ADDRESS 7632 S Kingshighway		23c. DATE SIGNED 2-28-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremaion		24b. DATE 2/28/52.		24c. NAME OF CEMETERY OR CREMATORY Missouri Crematory	
		24d. LOCATION (City, town, or county) (State) St Louis Mo			

DATE REC'D BY LOCAL REG. FEB 28 1952		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS L Ziegenhein & Sons 7027 Gravois	
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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 Nevelle B. Frohwitter

Licensed Embalmer No. 3696

P. O. Address 7027 Harris

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.