.S. No. 300
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32944

BIRTH NO. 54815 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7438

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

1. PLACE OF DEATH
a. COUNTY —
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
c. LENGTH OF STAY (in this place) 2 hrs. 35 min
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Evangelical Deaconess Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY St. Louis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rock Hill Village 4631
d. STREET ADDRESS (If rural, give location) 1210 Santa Fe Drive

3. NAME OF DECEASED (Type or Print)
a. (First) Vaughn
b. (Middle) Charles
c. (Last) Frandsen, Jr.

4. DATE OF DEATH (Month) (Day) (Year) August 3, 1952

5. SEX Male 0
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant 0
8. DATE OF BIRTH August 3, 1952
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours 2 Min. 35

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Missouri 0
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Vaughn Frandsen
13b. MOTHER'S MAIDEN NAME Leola Hellmann
14. NAME OF HUSBAND OR WIFE —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT'S SIGNATURE OR NAME Mr. V. Frandsen ADDRESS 1210 Santa Fe Dr

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atelectasis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Prematurity - 5 1/2 mos. gestation
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 7625

22. *I hereby certify that I attended the deceased from* August 3, 1952, *to* Aug 3, 1952, *that I last saw the deceased alive on* August 3, 1952, *and that death occurred at* 8:20 A *m., from the causes and on the date stated above.*

23a. SIGNATURE 0 (Degree or title) Frank G. Robertson M.D.
23b. ADDRESS 634 No. Grand Ave.
23c. DATE SIGNED 8-3-52

24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
24b. DATE Aug 4-52
24c. NAME OF CEMETERY OR ~~CREMATORY~~ Resurrection
24d. LOCATION (City, town, or county) (State) St Louis Co. Mo

DATE REC'D BY LOCAL REG. AUG 4 1952
REGISTRAR'S SIGNATURE J. Earl Smith M.D.
25. FUNERAL DIRECTOR'S SIGNATURE M. J. Crophan ADDRESS 7146 Manchester Ave

(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 Not Embalmed Student Embalmer No. ..... working under my personal supervision.

Student .....
Student Embalmer

Signed M. J. Creighton

Licensed Embalmer No. .....

P. O. Address .....

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.