

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **3101**
Registrar's No. **1026**

FILED FEB 17 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 6 mos. 13 days	
d. FULL NAME OF HOSPITAL OR INSTITUTION CITY INFIRMARY HOSPITAL		d. STREET ADDRESS (If rural, give location) 26 1446 Warren St.	
3. NAME OF DECEASED (Type or Print) a. (First) SUSAN		b. (Middle) _____ c. (Last) FRANKLIN	
4. DATE OF DEATH (Month) (Day) (Year) 1 23 1953		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	
8. DATE OF BIRTH 3-7-1861		9. AGE (In years last birthday) 91	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (City and State or Foreign Country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME John Keller		13b. MOTHER'S MAIDEN NAME Elizabeth	
14. NAME OF HUSBAND OR WIFE Widow		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME City Infirmery Records, 5800 Arsenal St.	
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) Cerebral arteriosclerosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis, general 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? 334x		22. I hereby certify that I attended the deceased from 7/10 , 19 52 , to 1/23/ , 19 53 , that I last saw the deceased alive on 1/23 , 19 53 , and that death occurred at 5:55A m., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) William M.weeney, M.D.		23b. ADDRESS 5600 Arsenal St.	
23c. DATE SIGNED 1/23/53		24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	
24b. DATE 1-29-53		24c. NAME OF CEMETERY OR CREMATORY City Crematory	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo		25. FUNERAL DIRECTOR'S SIGNATURE J. Ryan	
25. ADDRESS 5600 Arsenal		DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE Jan 28 1953	

(Licensed Embalmer's Statement on Reverse Side)

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 _____

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.