

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15699**
Registrar's No. **3560**

FILED APR 18 1953

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No. 300
10.48

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____	
1. PLACE OF DEATH a. COUNTY Missouri			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) 6 yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis 2129		
d. FULL NAME OF HOSPITAL OR INSTITUTION Masonic Hospital			d. STREET ADDRESS (If rural, give location) 5351 Delmar		
3. NAME OF DECEASED (Type or Print) a. (First) Jacob		b. (Middle) William		c. (Last) Franke	
4. DATE OF DEATH (Month) (Day) (Year) 4 3 1953					
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W		8. DATE OF BIRTH Nov. 3, 1859	
9. AGE (In years last birthday) 93		10. UNDER 1 YEAR Days 6	11. UNDER 1 HRS. Hours 4	12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Denmark	
13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE deceased Bertha Elizabeth Franke,	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME James H. Baker Supt. ADDRESS Masonic Home of Missouri, 5351 Delmar	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>			MEDICAL CERTIFICATION		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis			INTERVAL BETWEEN ONSET AND DEATH 2 Dys		
ANTECEDENT CAUSES DUE TO (b) Hypertension			6 Yrs.		
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 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 4201	
22. I hereby certify that I attended the deceased from 10-13- , 19 47 , to 4-3- , 19 53 that I last saw the deceased alive on 4-2- , 19 53 and that death occurred at 2:30A , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Robert P. Walker M.D.			23b. ADDRESS 508 N. Grand		23c. DATE SIGNED 4-3-53
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 4/6/53	24c. NAME OF CEMETERY OR CREMATORY VALHALLA Cem.		24d. LOCATION (City, town, or county) (State) ST. LOUIS, Mo.
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE APR 4 1953		REGISTRAR'S SIGNATURE Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Alexander & Sons 6175 Delmar	

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

(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 _____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed _____

Jos. E. McCulloch

Licensed Embalmer No. 2460

P. O. Address 6175 Dilmore

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.