FILED AUG 12 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26371

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6249

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2901 Osage

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY: St. Louis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Affton
d. STREET ADDRESS (If rural, give location): 8508 Gen. Grant Lane

3. NAME OF DECEASED (Type or Print)
a. (First): EMMA
b. (Middle):
c. (Last): GEORGE

4. DATE OF DEATH (Month) (Day) (Year): June 20 1953

5. SEX: F.
6. COLOR OR RACE: W.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Sept. 27 1871
9. AGE (In years last birthday): 81
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

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

13a. FATHER'S NAME: August Franke
13b. MOTHER'S MAIDEN NAME: Not Known
14. NAME OF HUSBAND OR WIFE: August George dcd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Russell Harstick 2901 Osage

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) Cardio Vascular Renal disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension
DUE TO (c) Arteriosclerosis

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 ☐ 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?: 442X

22. *I hereby certify that I attended the deceased from* 1/9, 1950, *to* 6/19, 1953, *that I last saw the deceased alive on* 6/19, 1953, *and that death occurred at* 1:45 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. G. Granet MD
23b. ADDRESS: 5521 S. Bdway
23c. DATE SIGNED: 6/20/53

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 6-23-53
24c. NAME OF CEMETERY OR CREMATORY: New St. Marcus Cemetery
24d. LOCATION (City, town, or county) (State): St. Louis Mo.

DATE REC'D BY LOCAL REG.: JUN 23 1953
REGISTRAR'S SIGNATURE: J. Carl Smith MD
MD
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Schumacher Und. Co 3013 Meramec

(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 Jack Haupt

Licensed Embalmer No. 4746

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.