

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **26887**  
**6670**

FILED AUG 12 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St Louis</b>		c. CITY OR TOWN <b>Arfton</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St Anthony Hospital</b>			
e. STREET ADDRESS <b>9850 Reavis</b>		4830 1	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Frank</b>	b. (Middle)	c. (Last) <b>Sebastian</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>July 4, 1953</b>
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>May 12, 1878</b>	9. AGE (In years last birthday) <b>75</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>St Louis Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Frank Sebastian</b>	13b. MOTHER'S MAIDEN NAME <b>Catherine Roth</b>	14. NAME OF HUSBAND OR WIFE <b>Lillie Sebastian</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>Lillie Sebastian</b>	ADDRESS <b>9850 Reavis</b>
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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		INTERVAL BETWEEN ONSET AND DEATH <b>about 1 1/2 yr</b>  <b>not known</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Celloid Carcinoma Caecum</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Leukemia, lymphogen</b>		
	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 <b>6-29-53</b>	19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma caecum (nigrosae)</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>no</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>153X</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **6-29-53**, 19**53**, to **6-4**, 19**53**, that I last saw the deceased alive on **6-4**, 19**53**, and that death occurred at **6:45P** m., from the causes and on the date stated above.

23a. SIGNATURE <b>W. H. Torrance</b>	(Degree or title) <b>MD</b>	23b. ADDRESS <b>9105 Gravois</b>	23c. DATE SIGNED <b>7-6-53</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>7/7/53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>SS Peter &amp; Paul Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>St Louis Mo.</b>
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>JUL 6 1953</b> <b>Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>J L Ziegenhein &amp; Sons</b>	ADDRESS <b>7027 Gravois</b>
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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.....  
Signature of Student Embalmer

Signed *C. P. Kidwell*

Licensed Embalmer No. *3877*

P. O. Address *7027 Gra*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.