

FILED OCT 15 1953

STANDARD CERTIFICATE OF DEATH
318

State File No. 34040
Registrar's No. 8799

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY 2257	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis Mo.		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION S. H. 9th St.		e. STREET ADDRESS (If rural, give location) 5 No 9th St.	
3. NAME OF DECEASED a. (First) Frank		b. (Middle)	c. (Last) Deak
4. DATE OF DEATH (Month) (Day) (Year) 8 27 53		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify)	
8. DATE OF BIRTH 1887		9. AGE (In years last birthday) 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (City and State or Foreign Country) Ireland		12. CITIZEN OF WHAT COUNTRY? 4	
13a. FATHER'S NAME none		13b. MOTHER'S MAIDEN NAME none	
14. NAME OF HUSBAND OR WIFE none		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or date of service) none	
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME W.C. Taylor	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Letar Pneumonia DUE TO (c) Right upper and Left upper Tubercular		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" 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) 002X	
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?			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE Joseph M. Deak		23b. ADDRESS 1300 Clark	
23c. DATE SIGNED 9/1/53		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE 9-30-53		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service	
DATE REC'D BY LOCAL REG. SEP 11 1953		REGISTRAR'S SIGNATURE J. Carl Smith	

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