

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3327

FILED FEB 2 1954

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State File No. ....

03772

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

1. PLACE OF DEATH a. COUNTY <u>St. Louis City</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Phelps</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis City</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. James</u>	
c. LENGTH OF STAY (In this place) <u>4 days</u>		d. STREET ADDRESS (If rural, give location) <u>High 7 Star Route</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Barnes Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Frank</u>	b. (Middle) <u>Colin</u>	c. (Last) <u>Suter</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>1-14-1954</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 13, 1898</u>	9. AGE (In years last birthday) <u>55</u>	IF UNDER 1 YEAR Month <u>3</u> Day _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (State or foreign country) <u>Cincinnati Ohio</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Dave Suter</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret Colin</u>	14. NAME OF HUSBAND OR WIFE <u>Bella S. Suter</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Bella S. Suter</u>	ADDRESS <u>High 7 Star Rte. St. James Mo.</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>BRAIN TUMOR, GLIOBLASTOMA</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last.  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 <u>1-12-54</u>	19b. MAJOR FINDINGS OF OPERATION <u>Same as above</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) (Min.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>193x</u>

22. I hereby certify that I attended the deceased from 1-12, 1954, to 1-14, 1954, that I last saw the deceased alive on 1-14, 1954, and that death occurred at 3:15 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>E. J. Vermillion, M.D.</u>	23b. ADDRESS <u>BARNES HOSPITAL</u>	23c. DATE SIGNED <u>1-14-54</u>
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24a. BURIAL CREMATION (Specify) <u>Burial</u>	24b. DATE <u>1-14-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Masonic Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. James Mo.</u>
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DATE REC'D BY LOCAL REG. <u>JAN 14 1954</u>	REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Paul A. ...</u>	ADDRESS <u>St. James Mo.</u>
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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. 3472

P. O. Address Cuba, Mo.

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.