

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24996

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5848**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS, MISSOURI		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN ST. LOUIS			
d. FULL NAME OF HOSPITAL OR INSTITUTION: ST. LOUIS CITY HOSPITAL		e. STREET ADDRESS (If rural, give location) 28 Unknown					
3. NAME OF DECEASED (Type or Print) FRANK		a. (First)		b. (Middle)			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE			
8. DATE OF BIRTH DEC. 8, 1887		9. AGE (In years last birthday) 66		4. DATE OF DEATH (Month) (Day) (Year) JUNE 24, 1954			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS			
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME JERMIAM		13b. MOTHER'S MAIDEN NAME FLORA			
14. NAME OF HUSBAND OR WIFE never married		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NIL			
17. INFORMANT'S SIGNATURE OR NAME HOSPITAL RECORD.		ADDRESS					
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia ? ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Brain Syndrome				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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? 491x		22. I hereby certify that I attended the deceased from 5-8-54 , 19___, to 6-24-54 , 19___, that I last saw the deceased alive on 6-24-54 , 19___, and that death occurred at 4:15A m. , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Samuel R Joseph M.D.		23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 6-24-54			
24a. BURIAL CREMATION, REMOVAL (Specify) Burial		24b. DATE 6-29-54		24c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery St. Louis, Mo.			
24d. LOCATION (City, town, or county) (State)		DATE REC'D BY LOCAL REG. JUN 29 1954		REGISTRAR'S SIGNATURE J. Carl Smith M.D.			
25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe		ADDRESS 4700 Washington.					

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 *John J. Harris*.....
Licensed Embalmer No. *410*.....

P. O. Address *Harris*.....

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.