

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38738**
10111

FILED NOV 22 1954

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)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		a. STATE Missouri b. COUNTY	
c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3457 A. Missouri Ave		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS 24 3457 A. Missouri Ave		(If rural, give location)	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)						
a. (First) William			b. (Middle)						
c. (Last) Frank			11-7-1954						
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 9-20-1878	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Hanger			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and State or Foreign Country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Jacob Frank		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Catherine Frank	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. 489-12-6063		17. INFORMANT'S SIGNATURE OR NAME Catherine Frank ADDRESS 3457 A. Missouri Ave	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Hemorrhage from Urinary tract and Gastro-intestinal tract		ANTECEDENT CAUSES		3 months	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) Cardiorenal vascular disease -		1944.	
		DUE TO (c) chronic nephritis, mitral regurgita			
		II. OTHER SIGNIFICANT CONDITIONS			
		Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION June 1949		19b. MAJOR FINDINGS OF OPERATION Prostatectomy for Prostatic hypertrophic and Urinary block		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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR 610X	

22. I hereby certify that I attended the deceased from **Jan 5, 1944**, to **Nov 7, 1954**, that I last saw the deceased alive on **Nov 7, 1954**, and that death occurred at **8:05 Am**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Leroy E. Ellison M.D.		23b. ADDRESS 3610 So Broadway St Louis Mo		23c. DATE SIGNED Nov 8, 1954	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11-10-1954		24c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cemetery	
				24d. LOCATION (City, town, or county) (State) 7903 Gravois Ave Mo	

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE NOV 8 1954		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 6409 Gravois Ave	
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Board and Marine Ave

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.....
Law M. Sizemore

Licensed Embalmer No. *434*

P. O. Address *St. Louis*

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.