

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2714**
Registrar's No. **172**

FILED JAN 25 1957

BIRTH NO. **91288-58** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St Louis		c. CITY OR TOWN St Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony Hosp		e. STREET ADDRESS (If rural, give location) 6016 Michigan	
3. NAME OF DECEASED (Type or Print) a. (First) DEBRA b. (Middle) K c. (Last) FRANK		4. DATE OF DEATH (Month) (Day) (Year) JAN 7 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Nov. 9 1956
9. AGE (In years last birthday) 2		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) girl	
11. BIRTHPLACE (City and State, Foreign Country) St Louis Mo		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Robert Frank		13b. MOTHER'S MAIDEN NAME Dorcas Clark	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no	
16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Robert Frank 6016 Michigan	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonitis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Developmental anomaly DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Status Lymphaticus	
19a. DATE OF OPERATION 1-7-57		19b. MAJOR FINDINGS OF OPERATION Pneumonitis	
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)	
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 11-9 1956 , to 1-7 1957 , that I last saw the deceased alive on 1-6 1957 and that death occurred at 3A m., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) C.A. Foster MD		23b. ADDRESS 5600 S Compton	
23c. DATE SIGNED 1-7-57		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 1-8-57		24c. NAME OF CEMETERY OR CREMATORY Malson Hill	
24d. LOCATION (City, town, or county) (State) Malson Hill		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS JOS. P. FENDLER JR. 7128 MICHIGAN	
DATE REC'D BY LOCAL REG. JAN 8 1957		REGISTRAR'S SIGNATURE J. Carl Smith MD	

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 *Clarence Cochran*.....

Licensed Embalmer No. *309*.....

P. O. Address *7128 Mc*.....

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.