

S. No. 300  
EV. 10.48

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **11504**

**FILED APR 15 1957**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **544** Registrar's No. **835**

1. PLACE OF DEATH a. COUNTY <b>ST LOUIS</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MO</b> b. COUNTY <b>OSCO JEFFERSON</b>		
b. CITY OR TOWN <b>KIRKWOOD</b>		c. LENGTH OF STAY (in this place) <b>6 days</b>	c. CITY OR TOWN <b>HOUSE SPRINGS</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST JOSEPHS Hosp.</b>			e. STREET ADDRESS (If rural, give location) <b>MERAMEC TOWNSHIP OSCO</b>		

3. NAME OF DECEASED (Type or Print) a. (First) <b>FRANK</b> b. (Middle) _____ c. (Last) <b>VOTAW</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>3 - 27 - 57</b>	
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>JAN 20 - 1877</b>	9. AGE (In years last birthday) <b>80</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>7</b>	IF OVER 1 YEAR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>HILLSBORO RA#2 - MO</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>
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13a. FATHER'S NAME <b>WILLIAM VOTAW</b>		13b. MOTHER'S MAIDEN NAME <b>RHODA KIDD</b>	14. NAME OF HUSBAND OR WIFE <b>NELLIE VOTAW</b>		
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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) <b>No.</b>	16. SOCIAL SECURITY NO. <b>49-28-0301A</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Nellie Votaw House Springs, Mo</b>			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Pancreatitis</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Generalized Arteriosclerosis</b>				

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			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) <b>5870</b>	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from **3/22**, 19**57**, to **3/27**, 19**57** that I last saw the deceased alive on **3/26**, 19**57**, and that death occurred at **p** m., from the causes and on the date stated above.

23a. SIGNATURE <b>Harold Huck M.D.</b> (Degree or title)		23b. ADDRESS <b>Fenton, Mo.</b>	23c. DATE SIGNED <b>3/28/57</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>3/31/57</b>	24c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL BAPTIST CEM.</b>	24d. LOCATION (City, town, or county) (State) <b>HILLSBORO RA#2 - MO</b>	
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DATE REC'D BY LOCAL REG. <b>3/29/57</b>	REGISTRAR'S SIGNATURE <b>Herbert A. Dombek</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Simms Funeral Home House Springs, Mo.</b>		
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

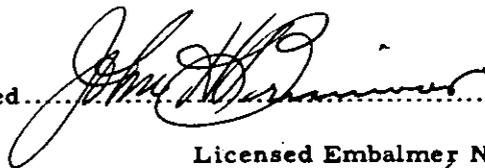
APR 25 1957

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. 1470

P. O. Address Home Springs, Ill.

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.