

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 14 1957

18653

STATE FILE NUMBER

318

1003

REGISTRAR'S 4834

Registration District No. Primary Registration District No.

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, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTE Homer Phillips Hosp.				Length of stay in 1b 22/78		d. STREET ADDRESS (If outside, give location) 2322 A. Cole	
3. NAME OF DECEASED (Type or print) First Frank Middle Forkner Last Jr.				4. DATE OF DEATH Month 5 Day 21 Year 57			
5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-28-1887	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) Robertson, Mo.	
13. FATHER'S NAME Frank Forkner				14. MOTHER'S MAIDEN NAME Not Known			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Mary Forkner-2322 A. Cole	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hemorrhage with Fracture of Skull; Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) E900.0 21						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? 1 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) Slipped when descending stairs at home of					
20c. TIME OF INJURY Hour 9:53 Month, Day, Year 5 14 57		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home					
20e. CITY, TOWN, OR LOCATION St. Louis Mo		20f. COUNTY STATE					
21. I attended the deceased from _____, to _____ and last saw her him alive on _____ Death occurred at 320 A _____ m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Deputy or wife) James M Kelly				22b. ADDRESS 1300 Clark		22c. DATE SIGNED 5-23-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 5-27-57		23c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.	
24. FUNERAL DIRECTOR ADDRESS A.L. Beal Und. Co.-4303 Delmar				25. DATE RECD. BY LOCAL REG. MAY 23 57		26. REGISTRAR'S SIGNATURE Carl Smith MS	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed: *Daniel W. Johnson*

Licensed Embalmer No 4802.

P. O. Address 4149 W.....
Kossuth

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.