

33506  
STATE FILE NUMBER 8926

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY OR TOWN <b>St. Louis Mo.</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Richmond Heights</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hos'p</b>		d. STREET ADDRESS <b>1029 Yale</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JULIUS</b> Middle <b>FRANK</b> Last _____		4. DATE OF DEATH Month <b>9</b> Day <b>23</b> Year <b>57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 29, 1877</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Jobber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ladies Accessories</b>	11. BIRTHPLACE (City and state or country) <b>Germany</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13a. FATHER'S NAME <b>Frank</b>	
13b. MOTHER'S MAIDEN NAME <b>Baer</b>		14. NAME OF HUSBAND OR WIFE <b>Maud F. Frank (Deceased)</b>	
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>488-63-2972</b>	17. INFORMANT Address <b>Mrs. Louis Saenger 1029 Yale</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Oedema, acute</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Cardiac Decompensation</b> DUE TO (c) <b>Arterio-sclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a) <b>450.0</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS,</b> <b>5 DAYS,</b> <b>See year</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input 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):		20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION _____		COUNTY _____ STATE _____	
21. I attended the deceased from <b>1950</b> to <b>Sep 23 '57</b> and last saw her alive on <b>Sep 23 '57</b> Death occurred at <b>3:00 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>P. D. Stahl M.D.</b> (Degree or title)		22b. ADDRESS <b>462 N. Taylor</b>	
22c. DATE SIGNED <b>9/24/57</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE <b>9/25/57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Sinai</b>	
23d. LOCATION (City, town, or county) <b>8400 Gravois St. Louis Co Mo.</b> (State)		24. FUNERAL DIRECTOR <b>Mayer</b> ADDRESS <b>4356 Lindell Blvd</b>	
25. DATE RECD. BY LOCAL REG. <b>SEP 24 57</b>		26. REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b> <b>S.P.</b>	

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 S. Dennis* .....

Licensed Embalmer No. *4194* .....

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.