

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38718

STATE FILE NUMBER

FILED OCT 16 1957

Registration District No. 312 Primary Registration District No. 500 Registrar's No. 2420

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bellefontaine Neighbors</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Bellefontaine Neighbors</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis State Fr. School</u>			Length of stay in 1b <u>10 yrs 8 mo. 15 days</u>		d. STREET ADDRESS <u>10695 Bellefontaine Rd</u>
3. NAME OF DECEASED (Type or print) First <u>CLINTON</u> Middle <u>-</u> Last <u>FRAZIER</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>28</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 14. 1940</u>	9. AGE (In years last birthday) <u>17 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo</u>	
13. FATHER'S NAME <u>J. C. FRAZIER</u>			14. MOTHER'S MAIDEN NAME <u>MILDRED CARTER</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>17. NONE</u>		17. INFORMANT <u>Friends of St. L. St. Fr. School</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho. Pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <u>Epilepsy</u> <u>353.3</u>					<u>since birth</u>
DUE TO (c) <u>Mental Deficiency</u>					<u>since birth</u>
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? YES <input 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 <u>a. m.</u> Month, Day, Year <u>p. m.</u>					
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 <u>January 13, 1948</u> <u>Sept. 28 1957</u> and last saw <u>him</u> alive on <u>Sept. 28, 1957</u> Death occurred at <u>7.15</u> <u>P.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Edward P. Hoff, M.D.</u>			22b. ADDRESS <u>St. Louis 10695 Bellefontaine Rd</u>		22c. DATE SIGNED <u>9/28/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-4-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>
24. FUNERAL DIRECTOR <u>Price Funeral Home - 2829 Washington</u>			25. DATE RECD. BY LOCAL REG. <u>10-1-57</u>		26. REGISTRAR'S SIGNATURE <u>Herbert B. Dornfe MD.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

Specifying the medical certificate in the special manner required by 1957-140 enacted 1947.

Health, & Welfare Public Services

300 1-56

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 *Leroy U. Bonmaster*

Licensed Embalmer No. *452*

P. O. Address *4251 Washington*

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.