

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-016784

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registered on **FILED MAY 10 1962** Primary Registration District No. **1003** Registrar's No. **3739**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1

3

4 0

5 0

6

7 1

8 1

9

10

11

12 75.3

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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 (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Length of stay in 1b	c. CITY OR TOWN <b>Koch</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>St. Louis City Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Koch Hospital</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Frank</b> Last <b>Frank</b>			4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>1962</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-22-1883</b>	9. AGE (last birthday) <b>79</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Dominick Frank</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Jane Simmons</b>		14. NAME OF HUSBAND OR WIFE <b>--</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>nil</b>	17. INFORMANT <b>Mrs. Elizabeth B. Zwierlein Los Angeles, Calif.</b> Address <b>5221 Village Green St.,</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>Cachexia; Malnutrition, plus</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Jaundice as a result of a c a of</b> DUE TO (c) <b>the head of the pancreas.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Calif.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>157x</b>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 _____ to _____ and last saw her alive on _____ Death occurred at <b>3:45P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Paul J. Simon</b> (Degree or title) <b>Deputy Coroner</b>		22b. ADDRESS <b>1300 Clark</b>		22c. DATE SIGNED <b>4-9-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>4-10-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis, Missouri</b>		
24. FUNERAL DIRECTOR <b>Albert H. Hoppe, Inc.</b>		ADDRESS <b>4700 Washington</b>	25. DATE RECD. BY LOCAL REG. <b>4-9-1962</b>	26. REGISTRAR'S SIGNATURE <b>Leon Smith, M.D.</b>	

DOCUMENT

MEDICAL CERTIFICATION

**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 Gay W. Wilkinson

Licensed Embalmer No. 3575

P. O. Address St Louis, Mo.

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.