

MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-033441

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District **1003**

Registrar's No. **8451**

FILED AUG 29 1963

VS 300
Rev. 4/59

1

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

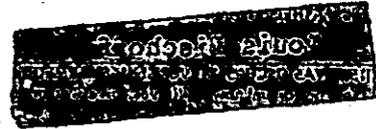
DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Length of stay in 1b 258 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>									
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Chronic				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) 1624 Park Ave.				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last Frank C. Bishop (Bischoff)hop			4. DATE OF DEATH Month Day Year 8 19 1963			5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10-10-85		9. AGE (last birthday) 77		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dock hand				10b. KIND OF BUSINESS OR INDUSTRY S. L. Long Warehouse Missouri				11. BIRTHPLACE (City and state or country) U.S.A.				12. CITIZEN OF WHAT COUNTRY U.S.A.							
13a. FATHER'S NAME Louise Bischoff				13b. MOTHER'S MAIDEN NAME Sophie Leonardise				14. NAME OF HUSBAND OR WIFE Josephine Barr				15. WAS DECEASED EVER IN U.S. ARMED FORCE (Yes, No, or Unknown) (If yes, give war, dates) No				17. INFORMANT Address Selma Mc Connell 3511 A Osage St. Louis Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 420.0												INTERVAL BETWEEN ONSET AND DEATH 8 hours 12 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)												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 type="checkbox"/> NO <input checked="" 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 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 12-4-62 to 8-19-63 and last saw her/him alive on 8-19-63 Death occurred at 7:20 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE (Degree or title) <i>Genneth Ch... M.D.</i>						22b. ADDRESS 5600 Arsenal			22c. DATE SIGNED 8/19/63										
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 8-21-63		23c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cemetery				23d. LOCATION (City, town, or county) St. Louis, Mo.											
24. FUNERAL DIRECTOR Witt Mortuary				ADDRESS 6409 Gravois Ave.				25. DATE RECD. BY LOCAL REG. AUG 20 1963		26. REGISTRAR'S SIGNATURE <i>Loed Smith, M.D.</i>									



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 J. Harris*
Licensed Embalmer No. 4108

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.