26 1939

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23297

Registration District No. 784 — 1939 JUL 6 1939 — Primary Registration District No. 200 — Registrar's No. 1124

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Vinita Park (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 8217 Washington Avenue (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community 17 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Vinita Park (If outside city or town limits, write "RURAL")
(d) Street No. 8217 Washington Avenue (If rural, give location)
(e) If foreign born, how long in U. S. A.? 29 years.

3. (a) PRINT FULL NAME Robert R. Franta
3. (b) If veteran, name war World
3. (c) Social Security No.
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Laura Franta
6. (c) Age of husband or wife if alive 43 years
7. Birth date of deceased April 14, 1896 (Month) (Day) (Year)

8. AGE: Years 43 | Months 2 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace ____ (City, town, or county) Bohemia (State or foreign country)
10. Usual occupation Tool and Die Worker
11. Industry or business Saur Machine Company
FATHER
12. Name Vaclav Franta
13. Birthplace ____ (City, town, or county) Bohemia (State or foreign country)
MOTHER
14. Maiden name Mary ---------
15. Birthplace ____ (City, town, or county) Bohemia (State or foreign country)
16. (a) Informant's own signature Mrs Laura Franta
(b) Address 8217 Washington Avenue
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/27/39 (Month) (Day) (Year)
(c) Place: burial or cremation Jefferson Barracks Mo.
18. (a) Signature of funeral director Shepard Funeral Home
(b) Address 1167 Hamilton Avenue. 7
19. (a) JUN 26 1939 (Date received local registrar) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 23, 1939
year 7 hour 15 minute P. M.

21. I hereby certify that I attended the deceased from May 8-39 ~~June 23~~, 1939, to June 23, 1939; that I last saw him alive on June 23-39, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Ceretral Hem (Left) — Duration 24 hrs
Due to Malignant Hyper-tension + advanced Arterio-Sclerosis
Due to
Other conditions Brights Disease (Include pregnancy within 3 months of death)
Major findings: Of operations None
Of autopsy None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ____
(b) Date of occurrence ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature Leo J Kelly (M. D. ~~or other~~)
Address 8105 Page Blvd. Date signed ____

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed J. G. Sullivan

Licensed Embalmer No. 1122

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

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Do not use this space.

1. PLACE OF DEATH
(a) County St. Louis — Registration District No. 784
(b) Township — Primary Registration District No. 200 — Registered No. 1124
(c) City — (d) Street No. — St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Robert R. Franta
(a) Residence, No. Vinita Park St. [ ] (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
m	w	m -

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
43	2	4	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE — DATE — 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED — 19 — Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 23, 19 9

22. I HEREBY CERTIFY That I attended deceased from ..., 19..., to ..., 19...
I last saw h... alive on ..., 19... Death is said to have occurred on the date stated above, at ...m.
The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage — Date of onset
Malignant hypertension
advanced arteriosclerosis
Other contributory causes of importance:
Brights disease ✓
Chronic — 2 yrs ago
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Name of operation — Date of
What test confirmed diagnosis? — Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? — Date of injury ..., 19...
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) Leo J. Reilly, M. D.
(Address) 8105 Page.

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.