

FILED SEP 24 1935  
Registration District No. 163

Primary Registration District No. 3031

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH: **Jefferson**  
 (a) County: **Mo Soto**  
 (b) City or town: **De Soto**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
(If apt in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution: **1**  
(Specify whether  
 In this community: \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State: **Missouri** (b) County: **Jefferson** **050**  
 (c) City or town: **De Soto**  
(If outside city or town limits, write "RURAL")  
 (d) Street No.: \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country: \_\_\_\_\_ **7:**

3. (a) PRINT FULL NAME: **William Frank**  
 3. (b) If veteran, name war: **--**  
 3. (c) Social Security No.: **--**

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **Nov.** day **2nd.**  
 year **1935** hour **3:** minute **30 P. M.**

4. Sex: **M**  
 5. Color or race: **W**  
 6. (a) Single, widowed, married, divorced: **Married**  
 6. (b) Name of husband or wife: **Gertrude**  
 6. (c) Age of husband or wife if alive: **70** years  
 7. Birth date of deceased: **April 3rd. 1868**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<b>67</b>	<b>6</b>	<b>29</b>	_____ hr. _____ min.

Immediate cause of death: **Cancer of the Stomach**  
 Duration: **1 yr.**

9. Birthplace: **St. Louis, Missouri**  
(City, town, or county) (State or foreign country)

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation: **Machinist**

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

11. Industry or business: **Frank**  
 12. Name: **unknown**  
 13. Birthplace: **Germany**  
(City, town, or county) (State or foreign country)  
 14. Maiden name: **Unknown**  
 15. Birthplace: **Germany**  
(City, town, or county) (State or foreign country)

Major findings: **Of operations**  
 Of autopsy: \_\_\_\_\_

16. (a) Informant: **Gertrude Frank**  
 (b) Address: **5000 South Broadway**

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?  
 While at work? \_\_\_\_\_  
(Specify type of place)  
 (e) Means of injury \_\_\_\_\_

17. (a) **Cremation**  
(Burial, cremation, or removal) (b) Date thereof: **Nov 5, 1935**  
(Month) (Day) (Year)  
 (c) Place: burial or cremation: **Missouri Crematory**

18. (a) Signature of funeral director: **Ziegenhein Bros.**  
 (b) Address: **6409 Gravois Ave.**

23. Signature: **Walter E. Gibson** (M. D. or D. O. M. D.)  
 Address: **De Soto, Mo.** Date signed: **9-21-43**

19. (a) **9-24-43** (Date received local registrar)  
 (b) **Mrs. Fern Spencer** (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

387

Refer to Affidavit folder for affidavit of Doctor Gibson and of the undertaker  
Ziegenhein Brothers. 6409 Gravois Ave. St. Louis, Missouri October Credits---1943

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. ....

Primary Registration District No. ....

Registrar's No. ....

1. PLACE OF DEATH:

(a) County.....  
(b) City or town De Soto, Missouri.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether

In this community.....  
years, months or days)

3. (a) PRINT FULL NAME William Frank

3. (b) If veteran, name war..... 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 Gertrude Frank. 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased. April 3rd, 1868  
(Month) (Day) (Year)

8. AGE: 67 Years 6 Months 29 Days (If less than one day, min.)

9. Birthplace Saint Louis, Missouri.  
(City, town, or county) (State or foreign country)

10. Usual occupation Machinist

11. Industry or business

12. Name Frank

13. Birthplace Unknown Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant Gertrude Frank.

(b) Address 5000 South Broadway

17. (a) Cremation (b) Date thereof Nov. 5, 1935.  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Missouri Crematory.

18. (a) Signature of funeral director Ziegenbein Bros.

(b) Address 6409 Gravois Ave.

19. (a) (b) (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County.....  
(c) City or town De Soto.  
(If outside city or town limits, write "RURAL")

(d) Street No..... (If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. Day 2nd, Year 1935. Hour 3 Minute 30 P. M.

21. I hereby certify that I attended the deceased from....., 19.....; that I have seen him/her alive on....., 19.....; and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

Due to.....  
Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:

Of operations.....

Of autopsy.....

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?

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

JUN 24 1944

JUN 24 1944

31911