

S. No. 2
M-5-43
v. 5-17-39
I X36671

12068

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED APR 15 1944

Registration District No. 3

Primary Registration District No. 6076

Registrar's No. 822

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town Lakewood
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
7816 Fleta
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis
(c) City or town Lakewood
(If outside city or town limits, write "RURAL")
(d) Street No. 7816 Fleta
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Rose Marie Frank

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex female 5. Color or race White 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 22, 1937
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
6 7 11 _____ hr. _____ min.

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

10. Usual occupation Student

11. Industry or business _____

12. Name Julius Frank

13. Birthplace St. Charles Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Bertha Wiese

15. Birthplace Spring Bluff Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Julius Frank

(b) Address 7816 Fleta

17. (a) burial (b) Date thereof 4/6/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Gerald, Missouri

18. (a) Signature of funeral director J L Liegenhein & Sons
(b) Address 7027 Gravois

19. (a) APR 7 - 1944 (b) E. V. McHarraw, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 3rd
year 1944 hour 1:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from March 26th, 1944 to April 3rd, 1944
that I last saw her alive on Apr. 3rd, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia 3 days
Duration _____

Due to _____

Due to _____

Other conditions Mitral regurgitation and
(Include pregnancy within 3 months of death)
Wood heart failure due to Rheumatoid

Major findings: Physician

Of operations _____
Of autopsy 928
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 _____

Signature Leo E. Wilniski (M. D. or other) M.D.

Address 5402 Gravois Date signed 4/14/44

St Louis, MO.

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

MOTHER FATHER

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.....

C. P. Indivell

Licensed Embalmer No. *3877*

P. O. Address *7027 Hawaii*

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.