

Registration District No. 47

Primary Registration District No. 3008

1. PLACE OF DEATH:

(a) County Calloway

(b) City or town Fulton  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
State Hospital No 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 days  
(Specify whether years, months or days)

In this community same

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis 14

(c) City or town St Louis County 1  
(If outside city or town limits, write "RURAL.")

(d) Street No. 1200 Grifule Place 2  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME PEARL 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 none 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: Jan 9 1914  
(Month) (Day) (Year)

8. AGE: Years 26 Months 6 Days 12 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation none

11. Industry or business none

MOTHER FATHER { 12. Name DK Alex Frank

13. Birthplace DK 9  
(City, town, or county) (State or foreign country)

14. Maiden name Mollie Meyer

15. Birthplace DK 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Records

(b) Address State Hospital No 1

17. (a) Burial (b) Date thereof 7-24-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walsh Hall at home

18. (a) Signature of funeral director W. M. ...

(b) Address 2204 Woodson Overland

19. (a) 7-21-1944 (b) Joseph Moravitz  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21 year 1944 hour 1 minute 35 A.M.

21. I hereby certify that I attended the deceased from July 12 1944 to July 21 1944  
that I last saw her alive on July 20 and that death occurred on the date and hour stated above.

Immediate cause of death Epileptic Convulsion  
renal metastasis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings: Of operations \_\_\_\_\_

Of autopsy renal metastasis  
Epilepsy (24 hrs) secondary to meningitis

Duration \_\_\_\_\_

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 \_\_\_\_\_

Signature R. E. ... (M. D. or other) \_\_\_\_\_

Address Fulton Mo Date Signed 7/21/44

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

14  
2

1147

*Wms. Macomber*  
*1027 W 7th St*  
**AUG 16 1944**

**RECEIVED**  
District Health Officer No. 9,  
District File Number.....  
Date Filed 8-10-44

**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 *Earl T. Hillman*

Licensed Embalmer No. 3501

P. O. Address *Overland 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 this body is not embalmed, fact should be so stated above.**