V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 4 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 6995

Registration District No. 310 Primary Registration District No. 3069 Registrar's No. 460

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

1. PLACE OF DEATH:

(a) County ST LOUIS

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

(c) Name of hospital or institution: ST MARYS HOSP O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 2 Weeks
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 0-00

(c) City or town ST LOUIS MO 17
(If outside city or town limits, write "RURAL")

(d) Street No. 1901 SO BROADWAY 9
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No) 1

If yes, name country .....

3. (a) PRINT FULL NAME JOYCE ELLOUISE FRAME

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

4. Sex F 1 5. Color or race W 6. (a) Single, widowed, married, divorced — 0

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

7. Birth date of deceased JAN (Month) 16 (Day) 1946 (Year)

8. AGE: Years | Months 1 | Days 4 | If less than one day 23 hr. 15 min.

9. Birthplace JONESBORO (City, town, or county) ARK 1 (State or foreign country)

10. Usual occupation INFANT

11. Industry or business .....

FATHER
12. Name ERNEST RAYMOND FRAME
13. Birthplace JONESBORO (City, town, or county) ARK 1 (State or foreign country)

MOTHER
14. Maiden name LOUISE MURPHY
15. Birthplace JONESBORO (City, town, or county) ARK 1 (State or foreign country)

16. (a) Informant Ernest R. Frame
(b) Address 1901 So Broadway

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 21-1946 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ MEMORIAL PARK CEM

18. (a) Signature of funeral director Wilson Jockey
(b) Address 6536 Clayton Rd

19. (a) 2-23-46 (Date received local registrar) (b) E.D. McGarian M.D. (Registrar's signature) MSA

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 20
year 46 hour 11 minute 15 P M.

21. I hereby certify that I attended the deceased from 2
4, 1946, to 2-20, 1946
that I last saw her alive on 2-20, 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death .....

Due to Hydrocephalus & meningomyelocele 157

Due to congenital malformation

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations none.
Of autopsy .....

Duration: since birth

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 0

23. Signature C. P. Lynxwiler (M. D. or other) M.D.
Address St. Marys Hospital Date signed 2-21-46

(Licensed Embalmer's Statement on Reverse Side)

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.....Not Embalmed

, 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.