

3. No. 2
-12-45
5-17-39
X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22231
6374
Registrar's No.

FILED JUL 31 1947

Registration District No. _____

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri Pacific Hospital
(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 Arkansas (b) County Phillips
(c) City or town Lexa
(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 _____

3. (a) PRINT FULL NAME Richard Isaac Frantz

3. (b) If veteran, name war No 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Grace Frantz 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased February 13 1870
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>4</u>	<u>20</u>	hr. _____ min.

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

10. Usual occupation Retired Engineer

11. Industry or business _____

MOTHER FATHER

12. Name Cornelius Frantz

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

14. Maiden name Unknown

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

16. (a) Informant Grace Frantz

(b) Address Lexa, Ark.

17. (a) Burial (b) Date thereof 7-6-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marana, Ark. Mo.

18. (a) Signature of funeral director Albert H. Honpe

(b) Address 4700 Washington Bld.

19. (a) JUL 4 1947 (b) J. F. Bredick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 3
year 1947 hour 3 minute 20 P. M.

21. I hereby certify that I attended the deceased from June 7
1947 to July 3 1947
that I last saw him alive on 3 July 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia

Due to Carcinoma Prostate gland

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

Major findings:
Of operations Carcinoma of Prostate
Of autopsy Carcinoma of Prostate

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 John M. Ellis M.D. (M.D. or other) M.D.
Address Mo. Pacific Hospital Date signed 3 July 47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SEP 0 1997

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

Ernest W. Spears

Licensed Embalmer No.

4080

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.