

FILED FEB 14 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 3447  
01132  
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>3663</u>		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY <u>St. Louis County</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clayton, Mo.</u>		c. LENGTH OF STAY (in this place) <u>10 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Berkeley City 76</u>		d. STREET ADDRESS (If rural, give location) <u>4100 Carson</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis Co. Hosp.</u>								
3. NAME OF DECEASED (Type or Print) a. (First) <u>Myrtle</u> b. (Middle) _____ c. (Last) <u>Frank</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 16, 1949.</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>wid.</u>		8. DATE OF BIRTH <u>1883</u>		
9. AGE (In years last birthday) <u>65</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 11 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) <u>9</u>		12. CITIZEN OF WHAT COUNTRY? ---	
13a. FATHER'S NAME <u>Unknown</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>JACOB FRANK</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>St. Louis County Hospital Records Clayton, Mo.</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Generalized carcinomatosis</u>  ANCECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma of the Rectosigmoid</u> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>46 d. 16 3 11</u>					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>Jan. 6th, 1949</u> , to <u>Jan. 16th, 1949</u> , that I last saw the deceased alive on <u>Jan. 16th, 1949</u> , and that death occurred at <u>11:55 a.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>R. R. Coble O.M.D.</u>			23b. ADDRESS <u>601 So. Brentwood, Clayton</u>			23c. DATE SIGNED <u>1-19-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		24b. DATE <u>1-19-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla</u>		24d. LOCATION (City, town or county) (State) <u>St. Louis Mo</u>		
DATE REC'D BY LOCAL REG. <u>1-19-49</u>		REGISTRAR'S SIGNATURE <u>Thurmond Lunge, MD</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis H. Bopp</u>			
			ADDRESS _____					

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

96223

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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.....

..... Student Embalmer No. ....

working under my personal supervision.

*No Embalming*

Signed.....

Signed.....  
Student Embalmer

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.