

FILED JAN 28 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2937
State File No. _____
730
Registrar's No. _____

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 730	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) a. STATE Missouri. b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri.		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis.		7-11-9	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Lukes Hospital..				d. STREET ADDRESS (If rural, give location) 5544 Chamberlain Ave.,			
3. NAME OF DECEASED (Type or Print) FREDERICK		a. (First)		b. (Middle) TURNER		c. (Last) RENCH.	
4. DATE OF DEATH (Month) (Day) (Year) Jan'y 23, 1950.							
5. SEX Male.		6. COLOR OR RACE White.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married.		8. DATE OF BIRTH Sep't 22, 1875.	
9. AGE (In years last birthday) 74.		IF UNDER 1 YEAR Months 4. Days 1.		IF UNDER 48 HRS. Hours 1. Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Gen. Agent..			10b. KIND OF BUSINESS OR INDUSTRY Life Ins Co, Vermont.			11. BIRTHPLACE (State or foreign country) Casapolis, Michigan.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13a. FATHER'S NAME (Unknown).		13b. MOTHER'S MAIDEN NAME Unknown.		14. NAME OF HUSBAND OR WIFE Stella May Rench.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If you give year or date of service) no.		16. SOCIAL SECURITY NO. none.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs F. T. Rench, 5544 Chamberlain Ave.,			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction					6 hours
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES					
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (b) Coronary artery arteriosclerosis and thrombosis anterior descending branch with					4-6 years
		DUE TO (c) Cardiac decompensation					6 hours
		II. OTHER SIGNIFICANT CONDITIONS					1 hour
		Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION Autopsy verified diagnosis				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE no (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN OR TOWNSHIP) (COUNTY) (STATE) St Louis Mo Mo			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4301			
22. I hereby certify that I attended the deceased from Jan 23, 1947 , to Jan. 23, 1950 , that I last saw the deceased alive on Jan 23, 1950 , and that death occurred at 9358 m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Joseph Rawaide M.D.				23b. ADDRESS 3720 Washington Blvd.		23c. DATE SIGNED 1/23/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial..U		24b. DATE Jan'y 25, 1950.		24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery.		24d. LOCATION (City, town, or county) (State) 7800 St. Charles Rock Rd.,	
DATE REC'D BY LOCAL REG. JAN 23 1950		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C.R. Lupton & Sons, 7233 Delmar Blv'd.,			

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

St. Louis
Date: 3/13/37.
Time: 2-5 P.M.

Box 11

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.

Student _____
Student Embalmer

Signed Arnold W Schoene

Licensed Embalmer No. 3864

P. O. Address St Louis, 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.