

FILED JUL 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21520

State File No. _____
Registrar's No. **5471**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS 2159	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3625 MORRANFORD		d. STREET ADDRESS (If rural, give location) 3625 MORRANFORD	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) MINNIE	b. (Middle)	c. (Last) FRANKE	Month JUNE	Day 23	Year 1950

5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH July 10, 1884	9. AGE (In years last birthday) 65	If UNDER 1 YEAR Months 11	If UNDER 1 YEAR Days 13	If UNDER 1 HR. Hours	If UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FINISHER		10b. KIND OF BUSINESS OR INDUSTRY EIY WALKER Co.		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME JOHN D. FRANKE		13b. MOTHER'S MAIDEN NAME ANNA GERIACH		14. NAME OF HUSBAND OR WIFE	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, not unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 488-06-3904	17. INFORMANT'S SIGNATURE OR NAME HATTIE STIRRAT		ADDRESS 3625 MORRANFORD	
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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) Chronic Myocarditis				8 months
ANTECEDENT CAUSES	DUE TO (b) Uremic Poisoning			8 months
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	DUE TO (c) Chronic Hypertension			8 months
II. OTHER SIGNIFICANT CONDITIONS	Conditions contributing to the death but not related to the disease or condition causing death. None.			

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION None		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) None	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office building, etc.) None	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) None
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) None	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? HT3X
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22. I hereby certify that I attended the deceased from **6-8 1950** to **6-23 1950**, that I last saw the deceased alive on **6-22 1950**, and that death occurred at **9:30 A. M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Harry L. Heidenreich M.D.	23b. ADDRESS 3750 Gravois	23c. DATE SIGNED 6-24-50
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24a. BURIAL, CREMATION (Specify) CREMATION	24b. DATE 6-24-50	24c. NAME OF CEMETERY OR CREMATORY MISSOURI CREMATORY	24d. LOCATION (City, town, or county) (State) ST. LOUIS Mo
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DATE REC'D BY LOCAL REG. JUN 23 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS 2906 Gravois
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Price

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.....

.....
working under my personal supervision.

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

Signed.....
Student Embalmer

Signed *Leo J. Budde*.....

..... Licensed Embalmer No. *3989*.....

..... 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.