

FILED JUN 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1003

State File No.

21936

5247

BIRTH NO. #46483		REG. DIST. NO. 318		PRIMARY REG. DIST. NO.		Registrar's No.		
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 2299				
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.				d. STREET ADDRESS (If rural, give location) 1709 So. 10th Street				
3. NAME OF DECEASED (Type or Print)			a. (First) MARGARET		b. (Middle) FRANDEL		c. (Last)	
4. DATE OF DEATH		(Month) June		(Day) 15th		(Year) 1950		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH 2-24-1863	9. AGE (In years last birthday) 87	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Potosi Mo		12. CITIZEN OF WHAT COUNTRY?		
13a. FATHER'S NAME Sam Small			13b. MOTHER'S MAIDEN NAME Margaret Foshee		14. NAME OF HUSBAND OR WIFE Charles			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Ellen Steff		ADDRESS 1009 1/2 Lafayette		
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcinoma of rectum with liver metastases ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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				20. AUTOPSY? YES <input 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 1374X				
22. I hereby certify that I attended the deceased from 3/27/50, 19__ to 5/15/50, 19__, that I last saw the deceased alive on 5/15/50, 19__, and that death occurred at 8:45am m., from the causes and on the date stated above.								
23a. SIGNATURE Dr. Norman Barber			23b. ADDRESS (Degree or title) M.D. 1515 Lafayette Ave.,		23c. DATE SIGNED 6/15/50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6-17-50		24c. NAME OF CEMETERY OR CREMATORY Mount Hope		24d. LOCATION (City, town, or county) (State) St. Louis County MO		
DATE REC'D BY LOCAL REG. JUN 15 1950		REGISTRAR'S SIGNATURE J. B. Foraker		25. FUNERAL DIRECTOR'S SIGNATURE M. Laughlin 2301 Lafayette				

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

James R Chapman

Signed.....
Student Embalmer

Licensed Embalmer No. *4550*

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.