

FILED AUG 14 1950

STANDARD CERTIFICATE OF DEATH

State File No. 22811

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 895

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	c. LENGTH OF STAY (in this place) 8-Hours	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph 0117	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital		d. STREET ADDRESS (If rural, give location) 1337 Buchanan Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Frank b. (Middle) c. (Last) Hart			4. DATE OF DEATH (Month) (Day) (Year) August 5, 1950		
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5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 0	8. DATE OF BIRTH Unk. 1888	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman		10b. KIND OF BUSINESS OR INDUSTRY ?	11. BIRTHPLACE (State or foreign country) Unk. Tenn. /		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Single	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 491-10-0797	17. INFORMANT'S SIGNATURE OR NAME Mrs D.R. Littler			ADDRESS 1337 Buchanan Ave.		
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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) Cardiac Asthma				Unknown	
		ANTECEDENT CAUSES					
		*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.					
		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				4342	
		Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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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)	
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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?	
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22. I hereby certify that I attended the deceased from July 30, 1950, to Aug 5, 1950 that I last saw the deceased alive on 8/5/50, and that death occurred at 10:20 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Mrs. Rodmond, MD		23b. ADDRESS St. Joseph, Mo		23c. DATE SIGNED 8/7/50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 0	24b. DATE 8-9-1950	24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri		
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DATE REC'D BY LOCAL REG. Aug 8, 1950	REGISTRAR'S SIGNATURE E. B. Jenkins 382		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hermann W. Spindler 1502 Lincoln		
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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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....

Robert H. Gable

Licensed Embalmer No. 3308

P. O. Address St Joseph, 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.