

FILED MAR 7 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6299

State File No.

1845

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** 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 town) OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		e. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
3. NAME OF DECEASED (Type or Print) a. (First) Frank b. (Middle) King c. (Last) (Also Known as) George SIX		4. DATE OF DEATH (Month) (Day) (Year) FEB. 23 1951	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb 21 1883
9. AGE (in years last birthday) 68	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Days 2	IF UNDER 11 HRS. Hours 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Kansas	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Kate Peters 1923 a Semple	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio Sclerosis Obliterans ANTECEDENT CAUSES Morbidity 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.	
19a. DATE OF OPERATION 2-18-51	19b. MAJOR FINDINGS OF OPERATION Gangrene of Rt Leg	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (a. 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 HSD	
22. I hereby certify that I attended the deceased from 1-26-51 , 19___, to 2-23-51 , 19___, that I last saw the deceased alive on 2-23-51 , 19___, and that death occurred at 9:33 P m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) R. R. Harrington MD		23b. ADDRESS 1515 Lafayette	23c. DATE SIGNED 2-23-51
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Feb. 26, 1951	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE FEB 23 1951 J. B. Luster	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sullivan Fun. Dir. 2849 N. Euclid		

(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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *Gustav H. Pietola*

Licensed Embalmer No. *4329*

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.