

FILED APR 27 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 14050

No. 300  
10-49

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3419

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS 2253	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Louis City Hospital #1		4. STREET ADDRESS (If rural, give location) 112 So. 4th 0	

3. NAME OF DECEASED (Type or Print) a. (First) FRANK	b. (Middle)	c. (Last) FEIST	4. DATE OF DEATH (Month) (Day) (Year) APR, 11 1951
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH 7-17-1898	9. AGE (In years last birthday) 52	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK	11. BIRTHPLACE (State or foreign country) SHIBOH ILLINOIS	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME MICHAEL FEIST	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE _____
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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. NONE	17. INFORMANT'S SIGNATURE OR NAME Gene Grandcolas	ADDRESS Rescued 3d
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxiation		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of Larynx		
	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	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)
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? 161X

22. I hereby certify that I attended the deceased from 3-9-51, 19\_\_, to 4-11-51, 19\_\_, that I last saw the deceased alive on 4-11-51, 19\_\_, and that death occurred at 12:35A m., from the causes and on the date stated above.

22a. SIGNATURE (Degree or title) W. Heurich, M.D.	23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 4-11-51
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24a. BURIAL, CREMATION, REMOVAL BURIAL	24b. DATE 4-13-51	24c. NAME OF CEMETERY OR CREMATORY SHIBOH	24d. LOCATION (City, town, or county) (State) SHIBOH ILLINOIS
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE APR 12 1951 J. B. Foster	25. FUNERAL DIRECTOR'S SIGNATURE Geo. Jenner, Belleville Ills
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(Licensed Embalmer's Statement on Reverse Side)

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

M-17

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.....

*not embalmed*

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed.....

*Geo. Renner*

Licensed Embalmer No. *2314*

P. O. Address *Belleville Ills*

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.