

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **39190**
10995

FILED DEC 15 1951

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 Mo. b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 8 months		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2149	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Pacific Hosp.				e. STREET ADDRESS (If rural, give location) 4931 Bernad			
3. NAME OF DECEASED (Type or Print) David Frank		a. (First)		b. (Middle)		c. (Last) James	
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH April 24 1885	
9. AGE (In years last birthday) 66		10. MONTHS 6		11. DAYS 16		12. IF UNDER 14 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) railroad engineer Mo Pacific				10b. KIND OF BUSINESS OR INDUSTRY Ino.			
11. BIRTHPLACE (State or foreign country) 1				12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME William James		13b. MOTHER'S MAIDEN NAME Louie Lenford		14. NAME OF HUSBAND OR WIFE Mary			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Mrs. M. James			
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) Coronary Occlusion ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) hypertensive Cardiovascular disease DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. myelitis incomplete				INTERVAL BETWEEN ONSET AND DEATH 12 hours	
19a. DATE OF OPERATION 4-23-51		19b. MAJOR FINDINGS OF OPERATION angioma of Conus medullaris				20. AUTOPSY? YES ☐ NO ☒	
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 ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR? 4201			
22. I hereby certify that I attended the deceased from Oct 10, 1951 , to Dec 10, 1951 , that I last saw the deceased alive on Dec 10, 1951 , and that death occurred at 7:45 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE George H. Hawkins		(Degree or title) M.D.		23b. ADDRESS 607 N Grand		23c. DATE SIGNED 11 Dec	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10/13/51		24c. NAME OF CEMETERY OR CREMATORY Calvary		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
DATE REC'D BY LOCAL REG. DEC 12 1951		REGISTRAR'S SIGNATURE Paul Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Jos. A. Howard			
				ADDRESS 1619 So. Grand			

(Licensed Embalmer's Statement on Reverse Side)

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

SEP 1 1960

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

John S. Penne
Licensed Embalmer No. *4194*
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.