

JUN 6 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18442

State File No. _____
Registrar's No. **4667**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. _____		Registrar's No. 4667			
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			c. LENGTH OF STAY (in this place) _____			c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			2199		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Louis City Hospital				d. STREET ADDRESS (If rural, give location) 4129 Laclede Ave.		19					
3. NAME OF DECEASED (Type or Print) a. (First) Frank			b. (Middle) _____			c. (Last) Resar			4. DATE OF DEATH (Month) (Day) (Year) May 18, 1952		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Oct. 4, 1876		9. AGE (In years last birthday) 75		10. MONTHS 7 11. DAYS 18 12. HOURS 11 MIN. 0	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Miner				10b. KIND OF BUSINESS OR INDUSTRY Coal				11. BIRTHPLACE (City and State or Foreign Country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Frank Resar				13b. MOTHER'S MAIDEN NAME Unknown				14. NAME OF HUSBAND OR WIFE Elizabeth			
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. 647-09-9195		17. INFORMANT'S SIGNATURE OR NAME Elizabeth Resar ADDRESS 4129 Laclede Ave.					
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) Acute Pneumonia; white									
		ANTECEDENT CAUSES hospitalized as a result of									
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. fractured left hip when he fell at Cedar Grove Nursing Home on Nov 18 1951									
		DUE TO (b) _____									
		II. OTHER SIGNIFICANT CONDITIONS exact time unknown									
		Conditions contributing to the death but not related to the disease or condition causing death.									
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION ooo Accident								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT (Specify) SMOKE ACCIDENT		21b. PLACE OF INJURY (e.g., to or about home, farm, factory, street, office, etc.) Nursing Home		21c. (CITY, TOWN, OR TOWNSHIP) _____		(COUNTY) _____		(STATE) _____			
21d. TIME OF INJURY Nov 18 51 p.m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? E9047							
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:15 a.m., from the causes and on the date stated above. 45											
23a. SIGNATURE Catharine E. Grayson (Degree or title) 3						23b. ADDRESS 1300 Clark		23c. DATE SIGNED 5:20:52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5-19-52		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) Coulterville, Ill.					
DATE REC'D BY LOCAL REG. MAY 20 1952		REGISTRAR'S SIGNATURE J. Carl Smith MD				25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe ADDRESS 4700 Washington Blvd					

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 Me

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed G. W. Wilkinson

Licensed Embalmer No. 35751

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.