

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **3149**
 Registrar's No. **0304**

FILED JAN 28 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital		d. STREET ADDRESS 5400 Arsenal St.	
3. NAME OF DECEASED (Type or Print) a. (First) FRANCES b. (Middle) GREEN c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Jan. 11, 1953
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan 11 1902
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 51
11. BIRTHPLACE (City and State or Foreign Country) Blattner Mo		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME John Benson		13b. MOTHER'S MAIDEN NAME Hester (Unknown)	14. NAME OF HUSBAND OR WIFE William Green
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS William Green 1729a So. 11th St.
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Huntington's Chorea DUE TO (c) Malnutrition 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"/>
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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 355X	
22. I hereby certify that I attended the deceased from Aug 14, 1944 , to Jan. 11, 1953 , that I last saw the deceased alive on Jan. 11, 1953 , and that death occurred at 8:05p m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Anthony K. Burch, M.D.		23b. ADDRESS 5400 Arsenal St.	23c. DATE SIGNED 1/12/53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan 14 53	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis Mo
DATE REC'D BY LOCAL REG. JAN 12 1953		REGISTRAR'S SIGNATURE J. C. Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E. J. Schnur 3125 Lafayette

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 _____

Joseph B. Ballmer

Licensed Embalmer No. *4044*

P. O. Address *3125 Lafayette*

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.