

FILED MAR 24 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11992**
Registrar's No. **2428**

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

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Incarnate Word Hospital		d. STREET ADDRESS (If rural, give location) 6130 Crescent Ave	

3. NAME OF DECEASED (Type or Print) FRANC			4. DATE OF DEATH (Month) (Day) (Year) MAY 3 3 1953		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH 8/4/1870		9. AGE (In years last birthday) 82		10. UNDER 1 YEAR Days 6 Hours 29	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Chicago Illinois	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME David A. Kusel		13b. MOTHER'S MAIDEN NAME Nellie ?		14. NAME OF HUSBAND OR WIFE Henry F. May	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Henry F. May 6130 Crescent	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH 4 hours
<p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral embolism			
		ANTECEDENT CAUSES			
		II. OTHER SIGNIFICANT CONDITIONS Chronic hypoglycemia, generalized arteriosclerosis, arteriovenous aneurysm Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Chronic hypoglycemia, coronary infarction		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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 332x	

22. I hereby certify that I attended the deceased from **7/5**, 19**50**, to **3/3/53**, 19**53**, that I last saw the deceased alive on **3/13/53**, 19**53**, and that death occurred at **2:15 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE J. Schatz (Degree or title) M.D.		23b. ADDRESS 2813 a Watson Road		23c. DATE SIGNED 3/4/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/5/53		24c. NAME OF CEMETERY OR CREMATORY Memorial Park	
		24d. LOCATION (City, town, or county) (State) St. Louis County Missouri			

DATE REC'D BY LOCAL REG. MAR 4 1953		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ambruster Mortuary 6633 Clayton Road	
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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

Ernest W. Spillard

Licensed Embalmer No. *4080*

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.