

FILED JUL-31 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **26343**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6391**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>6225 Sunshine Drive</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Nellie</b> b. (Middle) <b>Stutzke</b> c. (Last) <b>Frank</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>6-25-1953</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	
8. DATE OF BIRTH <b>3-24-1877</b>		9. AGE (In years last birthday) <b>76</b>		IF UNDER 1 YEAR Months Days IF UNDER 6 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					

13a. FATHER'S NAME <b>???? Stutzke</b>		13b. MOTHER'S MAIDEN NAME <b>Pauline Wenig</b>		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) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Marie Frank 6225 Sunshine Drive</b>	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <b>6/21/53+</b>	
<p><i>* This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i></p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic nephritis - Intestinal Hemorrhage</b>					
		ANTECEDENT CAUSES					
		<p>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</p> <p>DUE TO (b) _____</p> <p>DUE TO (c) _____</p>					
		II. OTHER SIGNIFICANT CONDITIONS					
		<p>Conditions contributing to the death but not related to the disease or condition causing death.</p>					

19a. DATE OF OPERATION <b>None</b>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>No</b>		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? <b>592X</b>	

22. I hereby certify that I attended the deceased from **6/21/53**, 19**53**, to **6/25/53**, 19**53**, that I last saw the deceased alive on **6/25/53**, and that death occurred at **6:45 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Bernard T. Koon M.D.</b>		23b. ADDRESS <b>4755 Morganford Road, St. Louis 16, Mo.</b>		23c. DATE SIGNED <b>6/26/53</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>6-29-1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Affton Mo Mo</b>	
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DATE REC'D BY LOCAL REG. <b>JUN 26 1953</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>W. B. Biegenheim Bros. 6409 Gravois Ave</b>	
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Dr. Koon 4755 A. Morganford HU 34341 1 till 6 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.....

.....  
working under my personal supervision.

Student Embalmer No. ....

Signed.....  
*Law M. Szymanski*

Signed.....  
Student Embalmer

Licensed Embalmer No. *4343*

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.