

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **33070**

FILED OCT 9 1953

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

Registrar's No. **84211**

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>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Lemay</b>	
c. LENGTH OF STAY (In this place) <b>17 days</b>		d. STREET ADDRESS (If rural, give location) <b>Box 2590</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>FRANCES</b> b. (Middle) <b>E.</b> c. (Last) <b>DANIEL</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 29, 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>Feb. 19, 1882</b>
9. AGE (In years last birthday) <b>71</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Brookfield, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
10a. USUAL OCCUPATION	10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		
13a. FATHER'S NAME <b>WILLIAM R. MEARA</b>	13b. MOTHER'S MAIDEN NAME <b>ELIZABETH SEEBACH</b>	14. NAME OF HUSBAND OR WIFE <b>Clyde E. Daniel</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mr. Clyde E. Daniel, Box 2590, Lemay, Mo.</b>	
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) <b>Myocardial Infarction</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>arterio sclerosis heart disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b> 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	
19a. DATE OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) <b>420.0</b>	
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?	
22. I hereby certify that I attended the deceased from <b>Aug 12, 1953</b> , to <b>29 Aug, 1953</b> , that I last saw the deceased alive on <b>29 Aug, 1953</b> , and that death occurred at <b>8:30 A.M.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Edward W. Gebinski M.D.</b>		23b. ADDRESS <b>3701 Grand St.</b>	23c. DATE SIGNED <b>8/29/53</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	24b. DATE <b>Sept. 1, 1953</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Pleasant View Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Kewanee, Ill.</b>
DATE REC'D BY LOCAL REG. <b>AUG 31 1953</b>	REGISTRAR'S SIGNATURE <b>J. Cash Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Reiderwieden F.H. Inc., 1936 St. Louis Ave.</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

0.300  
0.48

Dr. Edw. W. Czebrinski  
3701 Grandel Sq.  
12-3

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 \_\_\_\_\_

Licensed Embalmer No. 4520

P. O. Address H. Lewis, 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.