

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3083

FILED FEB 2 1954

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

State File No. 05777  
Registrar's No.

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

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 05777		Registrar's No.			
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. 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 OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
d. FULL NAME OF HOSPITAL OR INSTITUTION: Stix Baer Fuller					e. STREET ADDRESS (If rural, give location) 5 6007 Pershing Avenue 2059						
3. NAME OF DECEASED (Type or Print)			a. (First) Blanch		b. (Middle) Frankel		c. (Last) Meyers		4. DATE OF DEATH (Month) (Day) (Year) Jan 18, 1954		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, <input checked="" type="checkbox"/> MARRIED		8. DATE OF BIRTH Dec. 8, 1888		9. AGE (in years last birthday) 65		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager			10b. KIND OF BUSINESS OR INDUSTRY Resale shop			11. BIRTHPLACE (City and State or Foreign Country) Wilson Mills, Ohio			12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME Michael Frankel			13b. MOTHER'S MAIDEN NAME Esther Goodman			14. NAME OF HUSBAND OR WIFE Edward Meyers					
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. 499-34-4684			17. INFORMANT'S SIGNATURE OR NAME ADDRESS P.D. Stahl, M.D. 462 N. Taylor					
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, asphyxia, etc. It means the disease, injury, or complication which caused death.					MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage  ANTECEDENT CAUSES DUE TO (b) Hypertension Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH Immed.  Sev. yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION  331 X								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)						
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. HOW DID INJURY OCCUR						
22. I hereby certify that I attended the deceased from _____, 19____, to 1/18, 1954 that I last saw the deceased alive on 1/8/54, 19____, and that death occurred at 5:25 P.M., from the causes and on the date stated above.											
23a. SIGNATURE: P.D. Stahl M.D.					23b. ADDRESS: 462 N. Taylor Ave			23c. DATE SIGNED: 1/19/54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24b. DATE Jan. 20, 1954		24c. NAME OF CEMETERY OR CREMATORY Valhalla Chapel of Memories			24d. LOCATION (City, town, or county) (State) St. Louis County Mo.				
DATE REC'D BY LOCAL JAN 19 1954		REGISTRAR'S SIGNATURE J. Carl Smith			25. FUNERAL DIRECTOR'S SIGNATURE W. H. Mayer			ADDRESS 4350 Lindell Blvd ST. LOUIS, MO			

**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.....  
Signature of Student Embalmer

Signed... *Fred J. Larmer*

Licensed Embalmer No. *47*

P. O. Address *St. Louis*

**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 embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.  
If this body is not embalmed, fact should be so stated above.