

14842 - STANDARD CERTIFICATE OF DEATH
FILED MAR 26 1954 54
REG. DIST. NO. 77 PRIMARY REG. DIST. NO. 3016

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

1. PLACE OF DEATH a. COUNTY Cole		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri		b. COUNTY Cole	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Jefferson City, Mo.		c. LENGTH OF STAY (in this place) Life		c. CITY OR TOWN Jefferson City	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Marys Hospital		e. STREET ADDRESS (If rural, give location) 1117 Park		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or Print) a. (First) Theresa b. (Middle) Louise c. (Last) Frank			4. DATE OF DEATH (Month) (Day) (Year) March 17, 1954		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH March 13, 1954	9. AGE (In years last birthday) 0	10. MONTHS 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Jefferson City, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Joseph Frank	13b. MOTHER'S MAIDEN NAME Marjorie Markway	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>	16. SOCIAL SECURITY NO. <input type="checkbox"/>	17. INFORMANT'S SIGNATURE OR NAME Joseph Frank - Jefferson City, Mo.		18. ADDRESS Jefferson City, Mo.
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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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital heart disease		INTERNAL BETWEEN ONSET AND DEATH 3 days
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) autopsies were determined when autopsy finished		
	DUE TO (c)		
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 checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from 3-13, 1954, to 3-17, 1954, that I last saw the deceased alive on 3-17, 1954, and that death occurred at 12:25 AM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dean O'Day M.D.	23b. ADDRESS Jefferson City, Mo.	23c. DATE SIGNED 3-20-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3/18/54	24c. NAME OF CEMETERY OR CREMATORY St. George	24d. LOCATION (City, town, or county) (State) Linn, Mo.
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DATE REC'D BY LOCAL REG. Mar 24-54	REGISTRAR'S SIGNATURE R. P. Davis	25. FUNERAL DIRECTOR'S SIGNATURE Sylvester Dulle	ADDRESS J.C. Mo.
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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.....
Sylvester Rulle

Licensed Embalmer No. *4321*

P. O. Address *Jeffersonville*

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.