

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10819**

FILED APR 7 1954
BIRTH NO. REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **695**

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY [REDACTED] | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Koch, Missouri | | c. LENGTH OF STAY (In this place) 169 days | |
| c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | 2079 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Robert Koch Hospital | | d. STREET ADDRESS (If rural, give location) 4919 Leaky 1 | |

| | | | | |
|-------------------------------------|-------------------------|-------------------------------|--------------------------|--|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Frank | b. (Middle) [REDACTED] | c. (Last) Stubits | 4. DATE OF DEATH (Month) (Day) (Year) 3 17 1954 |
|-------------------------------------|-------------------------|-------------------------------|--------------------------|--|

| | | | | | | |
|--------------------|-------------------------------|---|------------------------------------|--|------------------|-----------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 10-15-1881 | 9. AGE (In years last birthday) 72y | 10. UNDER 1 YEAR | 11. UNDER 1 HR. |
|--------------------|-------------------------------|---|------------------------------------|--|------------------|-----------------|

| | | | |
|--|---|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) polisher, fire plan | 10b. KIND OF BUSINESS OR INDUSTRY Brick and Fix plan | 11. BIRTHPLACE (City and State or Foreign Country) Austria | 12. CITIZEN OF WHAT COUNTRY? First Citizenship papers |
|--|---|---|--|

| | | |
|--|---|---|
| 13a. FATHER'S NAME Sydney Stubits | 13b. MOTHER'S MAIDEN NAME [REDACTED] | 14. NAME OF HUSBAND OR WIFE Anna Stubits |
|--|---|---|

| | | | |
|---|---|--|--------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 492-05-4012 | 17. INFORMANT'S SIGNATURE OR NAME A. Stephen Morrison, M.D. | ADDRESS Koch, Mo. |
|---|---|--|--------------------------|

| | | | |
|---|---|---|---|
| 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 | | INTERVAL BETWEEN ONSET AND DEATH ca 2 years |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) pulmonary tuberculosis, active | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | |
| II. OTHER SIGNIFICANT CONDITIONS silicosis? cerebral arteriosclerosis. Arteriosclerotic gangrene of left foot | | Conditions contributing to the death but not related to the disease or condition causing death. | |

| | | |
|------------------------|--|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION 002X | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|--|--|

| | | |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) [REDACTED] | 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? |
|--|--|----------------------------|

22. I hereby certify that I attended the deceased from **9-29, 1953**, to **3-17, 1954**, that I last saw the deceased alive on **3-16, 1954**, and that death occurred at **6:14 a.m.**, from the causes and on the date stated above.

| | | |
|---|---|---------------------------------|
| 23a. SIGNATURE (Degree or title) Bernard Lewin, M.D. | 23b. ADDRESS Robert Koch Hospital, Koch, Mo. | 23c. DATE SIGNED 3-17-54 |
|---|---|---------------------------------|

| | | | |
|--|--------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE 3-20-54 | 24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | 24d. LOCATION (City, town, or county) (State) St. Louis, Mo. |
|--|--------------------------|--|---|

| | | | |
|---|--|--|---------------------------------|
| DATE REC'D BY LOCAL REG. 3/18/54 | REGISTRAR'S SIGNATURE Herbert R. Donkey | 25. FUNERAL DIRECTOR'S SIGNATURE Harrigan & Sheahan | ADDRESS 4700 Washington. |
|---|--|--|---------------------------------|

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

104 3M

203

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 *JWM Binkley*

Licensed Embalmer No. *3653*

P. O. Address *St Louis 8 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.