

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 17 1954

State File No. **42908**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **11302**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS Mo		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN ST. LOUIS
d. FULL NAME OF HOSPITAL OR INSTITUTION 4136 WYOMING		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS 4136 WYOMING		f. ZIP CODE 63169	

3. NAME OF DECEASED (Type or Print) a. (First) FRANK b. (Middle) c. (Last) UTRY	4. DATE OF DEATH (Month) (Day) (Year) DEC. 10 1954
--	--

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH FEB. 20 1897	9. AGE (In years last birthday) 57 If UNDER 1 YEAR: Months _____ Days _____ If UNDER 14 yrs: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BAKER	10b. KIND OF BUSINESS OR INDUSTRY BENTON BAKERY	11. BIRTHPLACE (City and State or Foreign Country) AUSTRIA HUNGARY		12. CITIZEN OF WHAT COUNTRY? 1

13a. FATHER'S NAME FRANK UTRY	13b. MOTHER'S MAIDEN NAME KATHERINE LAHRENBACH	14. NAME OF HUSBAND OR WIFE HELEN UTRY
--------------------------------------	---	---

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. 492-01-1950	17. INFORMANT'S SIGNATURE OR NAME HELEN UTRY ADDRESS 4136 WYOMING
--	--	---

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 7 mo.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of sigmoid colon with colostomy fistula		
	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 Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Inoperable carcinoma of sigmoid	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 153X
--	--	--

22. I hereby certify that I attended the deceased from **9-2**, 1954, to **12-10**, 1954, that I last saw the deceased alive on **12-9**, 1954, and that death occurred at **1 a.** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Sam Schneider M.D.	23b. ADDRESS 4652 Maryland	23c. DATE SIGNED 12/14/54
--	-----------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE DEC. 13 1954	24c. NAME OF CEMETERY OR CREMATORY RESURRECTION	24d. LOCATION (City, town, or county) (State) ST. LOUIS Mo
--	-------------------------------	--	---

DATE REC'D BY LOCAL REG. DEC 13 1954	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Thomas Katis ADDRESS 2906 Grand
---	---	--

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 Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed: *James C. Dill*

Licensed Embalmer No. *4349*

P. O. Address *2906*

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.