

No. 300  
10-48  
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **13788**  
**3185**

FILED APR 18 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	c. LENGTH OF STAY (If this place) <b>32-days</b>	c. CITY OR TOWN <b>St. Louis</b>	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 <b>DePaul Hospital</b>		STREET ADDRESS (If rural, give location) <b>3 6926 Arthur Ave. 2039</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Frank</b>	b. (Middle) <b>X.</b>	c. (Last) <b>Price</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>April 7, 1955</b>
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>M.</b>	8. DATE OF BIRTH <b>April 5, 1895</b>
9. AGE (In years last birthday) Months Days <b>60 0 2</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guide- Anheuser-Busch Inc.</b>	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	

13a. FATHER'S NAME <b>Charles F. Price</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Burke</b>	14. NAME OF HUSBAND OR WIFE <b>Mrs. Eleanor Price</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>489-03-0565</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Eleanor Price, 6926 Arthur Ave.</b>

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Uremia due to post-operative shock</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Common duct obstruction (stones) + acute gangrene of gall bladder</b> 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 <b>2 wks</b>
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>584X</b>

22. I hereby certify that I attended the deceased from **10-29, 1950**, to **4-7, 1955**, that I last saw the deceased alive on **4-6, 1955**, and that death occurred at **8:20 AM.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Wayne O. Gerke MD</b>	(Degree or title)	23b. ADDRESS <b>2739 N. Grand</b>	23c. DATE SIGNED <b>4-8-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>April 11, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
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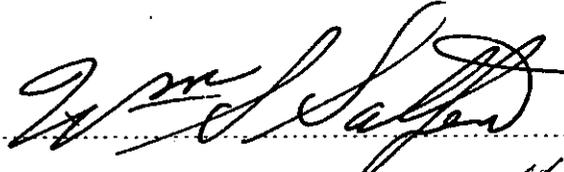
DATE REC'D BY LOCAL REG. <b>APR 9 1955</b>	REGISTRAR'S SIGNATURE <b>Carl Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>ms. Director J. Lomedy</b>	ADDRESS <b>810 Lindell Blvd.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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 me....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed .....

Licensed Embalmer No.....465

P. O. Address.....

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.