

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31743
State File No.

FILED SEP 22 1955

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 541 Registrar's No. 2122

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give town OR <u>Clayton</u>)	c. LENGTH OF STAY (in this place) township) <u>3 Days</u>	c. CITY OR TOWN <u>St. Ann</u>	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 <u>St. Louis County Hospital</u>		STREET ADDRESS (If rural, give location) <u>3734 Wright Ave.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>DAVID</u> b. (Middle) <u>B</u> c. (Last) <u>FRAME</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 10 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 16, 1925</u>	9. AGE (In years last birthday) <u>30</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Medicine</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>William Frame</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Jane Wright</u>	14. NAME OF HUSBAND OR WIFE <u>Esther Frame</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W. 2</u>	16. SOCIAL SECURITY NO. <u>488-20-7922</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Esther Frame 3734 Wright Ave.</u>

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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Colon & metastases to Lungs</u>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) 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.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>153X</u>	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)	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 9-7-55, 1955, to 9-10, 1955, that I last saw the deceased alive on 9-10, 1955, and that death occurred at 6:35 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Robert E. Froelich, M.D.</u>	23b. ADDRESS <u>601 S. BRENTWOOD</u>	23c. DATE SIGNED <u>9-11-1955</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Sept 13 55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>
		24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>

DATE REC'D BY LOCAL REG. <u>9-12-55</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Domb</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Collier Mortuary 10123 St. Chas. Rd.</u>
---	--	--

S.G.

(Licensed Embalmer's Statement on Reverse Side)

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 *Sheldon Collier*.....

Licensed Embalmer No. *33*

P. O. Address *10123 St. t*

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.