

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **34885**  
**9015**

FILED OCT 24 1955

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give townshp) OR TOWN <b>ST. LOUIS, MISSOURI.</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>ST LOUIS</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL</b>				e. STREET ADDRESS (If rural, give location) <b>26 2108 DESTRAHAN</b>				
3. NAME OF DECEASED (Type or Print) <b>FRANK</b>			a. (First)		b. (Middle) <b>JOSAR</b>		c. (Last)	
4. DATE OF DEATH <b>OCT. 15, 1955</b>		(Month)		(Day)		(Year)		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWER</b>		8. DATE OF BIRTH <b>JUNE 14 - 1883</b>		
9. AGE (in years last birthday) <b>72</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Mins. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Packing House Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>			11. BIRTHPLACE (City and State or Foreign Country) <b>YOU GOSLAUVA</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>FRANK JOSAR</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Deceased</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>490-22-4982</b>		17. INFORMANT'S SIGNATURE OR NAME <b>John Josar - 2108 Destrahan</b>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic Heart Disease</b>						
		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 <b>420.0</b>				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) _____ m. _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from <b>9-16</b> , 1955, to <b>OCT. 15</b> , 1955, that I last saw the deceased alive on <b>10-15</b> , 1955, and that death occurred at <b>6:20 a.m.</b> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <b>Ireland W. Kimball M.D.</b>				23b. ADDRESS <b>1515 LAFAYETTE AVE.</b>		23c. DATE SIGNED <b>10-15-55.</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>10-18-1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo</b>		
DATE REC'D BY LOCAL REG. <b>OCT 17 1955</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Eur Koh + Son - 3516 N. 14th</b>				

S.P. (Licensed Embalmer's Statement on Reverse Side)

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

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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..... *Ben E. Hoffmann*

Licensed Embalmer No. *43*

P. O. Address..... *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.