

52 JUN 4 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

17444

State File No. ....

BIRTH NO. .... REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 152

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Charles</u>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <u>St. Peters,</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>St. Joseph Hospital</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
		* STREET ADDRESS (If rural, give location) <u>4 mi. so. on Cottleville rd</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Frank</u> b. (Middle) <u>Joseph</u> c. (Last) <u>Wies</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>May 29, 1956</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 30, 1899</u>	9. AGE (In years last birthday) <u>57</u>	IF UNDER 1 YEAR: Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Peters, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME <u>Joseph Wies</u>	13b. MOTHER'S MAIDEN NAME <u>Emma Ochs</u>	14. NAME OF HUSBAND OR WIFE <u>Helen Wies</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>488-26-0944</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Helen Wies, RRL, St. Peters, Mo.</u>	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Heart Disease</u>		
	ANTECEDENT CAUSES Morbidity 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. <u>Peripheral Vascular Disease</u>			

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

22. I hereby certify that I attended the deceased from Sept 1953, to 28 May, 1954, that I last saw the deceased alive on 28 May, 1954, and that death occurred at 3:58 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Vene J. Durovator</u>	23b. ADDRESS <u>O'Fallon, Mo</u>	23c. DATE SIGNED <u>5/29/56</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	24b. DATE <u>6-1-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Cottleville, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>June 1, 1956</u>	REGISTRAR'S SIGNATURE <u>Hamil Hamilton</u>	FUNERAL DIRECTOR'S SIGNATURE <u>Geo. Stiefvater</u>	ADDRESS <u>St. Peters, Mo.</u>
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JUN 14 1956

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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 *E. A. Keittley*

Licensed Embalmer No. *80*

P. O. Address *O Falls*

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.