

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2719**
Registrar's No. **247**

FILED JAN 29 1957

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) City Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) Clarence		b. (Middle)	
c. (Last) Frost		4. DATE OF DEATH (Month) (Day) (Year) January 1, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED/ WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 17 1894
9. AGE (In years last birthday) 62		IF UNDER 1 YEAR Months	IF UNDER 1 Wks. Days
10a. USUAL OCCUPATION (Give kind of work done during year immediately preceding even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY Building	11. BIRTHPLACE (City and State or Foreign Country) / Illinois
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Unknown	
13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Edna Frost	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Edna Frost 3507 Blair Ave.			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bleeding Peptic Ulcer 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. 540.0	
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)		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 2:10 P.M. , from the causes and on the date stated above.			
23. SIGNATURE Robert J. Sullivan (Degree or title) Deputy Coroner		23b. ADDRESS 1300 Clark	
23c. DATE SIGNED 1/2/57		24a. BURIAL, CREMATION, OR OTHER DISPOSITION Burial	
24b. DATE 1/4/57		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis County Mo		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS SULLIVAN'S 2849 No. Euclid	
DATE REC'D BY LOCAL REG. JAN 9 1957		REGISTRAR'S SIGNATURE Carl Smith MEB	

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 *Albert S. Maguire*.....
Licensed Embalmer No. *9077*.....

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.