

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6066

State File No.

FILED FEB 25 1957

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1021**

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. LENGTH OF STAY (In this place)	c. CITY OR TOWN St. Louis		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 Frank James Chesnick 2247 University			e. STREET ADDRESS (If rural, give location) 2247 University St.		
3. NAME OF DECEASED (Type or Print) a. (First) Frank b. (Middle) James c. (Last) Chesnick			4. DATE OF DEATH (Month) (Day) (Year) 1 / 29 / 57		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 1st. 1901		9. AGE (In years last birthday) 55 if UNDER 1 YEAR Months Days if UNDER 1 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Checker		10b. KIND OF BUSINESS OR INDUSTRY Riss Co.	11. BIRTHPLACE (City and State or Foreign Country) St. Louis		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Frank Chesnick		13b. MOTHER'S MAIDEN NAME Mary Michalski		14. NAME OF HUSBAND OR WIFE Mary Ann Chesnick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 11 492-05-1035	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Mary Chesnick 2247 University		
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) Pulmonary Oedema ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Insufficiency DUE TO (c) Cardiac Hypertrophy			INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? 1 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) 4201		
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 _____ 19____, to _____ 19____, that I last saw the deceased alive on _____ 19____, and that death occurred at 1140 a.m., from the causes and on the date stated above.					
23a. SIGNATURE Patricia C. Taylor (Degree or title) 3			23b. ADDRESS 1300 Clark		23c. DATE SIGNED 1.31.57
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2/2/57	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
DATE REC'D BY LOCAL REG. JAN 31 '57		REGISTRAR'S SIGNATURE J. Paul Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert D. Kinealy 2228 St. Louis Av	

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.....

Licensed Embalmer No. 495

P. O. Address St. Louis

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.