Health, & Welfare Public Service

S. 300 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED SEP 17 1957

33404

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8270

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) ST. LOUIS — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Louis City Hosp. #1 — Length of stay in 1b 20Days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE St.Louis b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 1723 S. 9th — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First FRANK Middle Last DELINE

4. DATE OF DEATH Month Aug. Day 31 Year 1957

5. SEX Male
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]
8. DATE OF BIRTH May 29, 1897
9. AGE (In years last birthday) 60 — 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) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (City and state or country) St.Louis,Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME John Deline
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE None

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW #1
16. SOCIAL SECURITY NO. Yes (Unk)
17. INFORMANT Jennie Chartrand, Address 1723 S. 9th, St.Louis,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic pyelonephritis — INTERVAL BETWEEN ONSET AND DEATH unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 600.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) uremia

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 8/11/57, to 8/31/57 and last saw [X] him alive on 8/31/57
Death occurred at 10:45 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Jean A. Chapman MD
22b. ADDRESS 1515 Lafayette Ave.
22c. DATE SIGNED 9/3/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 9-5-57
23c. NAME OF CEMETERY OR CREMATORY National
23d. LOCATION (City, town, or county) (State) Jefferson Brk's., Mo.

24. FUNERAL DIRECTOR ADDRESS McLaughlin Funeral Home Inc. 2301 Lafayette, St.Louis, Mo.
25. DATE RECD. BY LOCAL REG. SEP 4 57
26. REGISTRAR'S SIGNATURE J Carl Smith MD MDB.

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 James R. Chapman

Licensed Embalmer No. 4550

P. O. Address St. Louis, M

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.