

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34404

STATE FILE NUMBER

FILED SEP 23 1957

Registration District No. 317

Primary Registration District No. 544

Registrar's No. 2203

Health, Welfare & Public Service
 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. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

County
 4803

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|---|----------------------------------|---|--|--|--|--|---|-------|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>Sappington 48300</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u> | | | Length of stay in 1b <u>3 days.</u> | | d. STREET ADDRESS (If outside, give location) <u>9551 Eddie & Park</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle _____ Last <u>Ebl</u> | | | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>3</u> Year <u>1957</u> | | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>June 18, 1885</u> | | 9. AGE (In years last birthday) <u>72</u> | IF UNDER 1 YEAR Months _____ Days _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(retired) Machinist</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Anheuser-Busch</u> | | 11. BIRTHPLACE (City and state or country) <u>Hungary</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>----- Frank</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown -----</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | 17. INFORMANT Address <u>Anna Abl-9551 Eddie & Park Rd.</u> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Esophageal varicose rupture</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) <u>Cirrhosis, liver</u> | | DUE TO (c) <u>5810</u> | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT <input type="checkbox"/> | SUICIDE <input type="checkbox"/> | HOMICIDE <input type="checkbox"/> | 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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 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 <u>8-30-57</u> to <u>8-3-57</u> and last saw ^{him} alive on <u>9-3-57</u> Death occurred at <u>1:00 A m</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Robert M. Richardson M.D.</u> | | | | 22b. ADDRESS <u>P.O. Bx 6 Sappington Mo</u> | | 22c. DATE SIGNED <u>9-9-57</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>Sept. 6, 1957</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u> | | 23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u> | | | |
| 24. FUNERAL DIRECTOR <u>WACKER-HELDERLE-3634 Gravois Ave.</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>9-4-57</u> | | 26. REGISTRAR'S SIGNATURE <u>Herbert R. Donohue</u> | | |

asc

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 *Robert C. Johnson*.....

Licensed Embalmer No. *21*.....

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

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