

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

45921  
STATE FILE NUMBER  
12116

FILED DEC 30 1957

Registration District No. 318 Primary Registration District No. 1003

V. S. 300  
Rev. 1-57

Securing the medical certification in the specific manner required by 193.140 MoRS 1949.  
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  
MEDICAL CERTIFICATION

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, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		d. STREET ADDRESS (If outside, give location) 2216 2838 Walnut	
Length of stay in lb		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED First Middle Last FRANK HINKLE			4. DATE OF DEATH DEC. 12. 1957 Month Day Year
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12-1890
9. AGE (In years last birthday) 67 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. BIRTHPLACE (City and state or country) Labordie, Mo.
10a. USUAL OCCUPATION		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Sam Hinkle		14. NAME OF HUSBAND OR WIFE Anna Hinkle	
13b. MOTHER'S MAIDEN NAME Julia ?		14. NAME OF HUSBAND OR WIFE Address Anna Hinkle 2838 Walnut St.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, state dates of service) Yes		16. SOCIAL SECURITY NO. 1400-23-242	
17. INFORMANT Anna Hinkle		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident Pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) 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 type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 331x	
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.) Mo.	
20c. TIME OF INJURY . Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 12/5/57 to 12/12/57 and last saw her alive on 12/12/57 Death occurred at 6:15 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Joseph Drew Callabow M.D.	
22b. ADDRESS 1515 LAFAYETTE AVE.		22c. DATE SIGNED 12/13/57	
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 18/1957	
23c. NAME OF CEMETERY OR CREMATORY Jefferson Barracks		23d. LOCATION (City, town, or county) (State) St. Louis Co Mo.	
24. FUNERAL DIRECTOR Russell Undertaking Co. 2732 Pine St.		25. DATE RECD. BY LOCAL REG. DEC 17 57	
26. REGISTRAR'S SIGNATURE Carl Smith Mo m 83			

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 G. Carter*

Licensed Embalmer No. *1461*

P. O. Address *St. Louis, Mo.*

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.