

Health,  
Welfare  
Public  
Service

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED DEC 20 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 46548

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2952

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clayton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Velda Village 4180</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis Hospital</b>		County <b>County</b> Length of stay in lb <b>1 day</b>	d. STREET ADDRESS <b>6825 St. Charles</b>		(If outside, give location) <b>Rock Rd</b> Reside on Farm <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Buck</b> Last <b>Buck</b>			4. DATE OF DEATH Month <b>11</b> Day <b>23</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 20, 1891</b>	9. AGE (In years last birthday) <b>65</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Boiler Works</b>	11. BIRTHPLACE (City and state or country) <b>New Castle, Wyoming</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes World War 1</b>		16. SOCIAL SECURITY NO. <b>488-18-4505</b>	17. INFORMANT <b>Mrs. Lydia Buck</b> Address <b>6825 St. Charles Rock Rd.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b); and (c):] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Central vascular accident (hemorrhage)</b> Conditions, if any, which gave rise to above cause (a); stating the underlying cause last. DUE TO (b) <b>Central arteriosclerosis</b> DUE TO (c) <b>331X</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive cardiovascular disease</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <b>8:35</b> Month <b>11</b> Day <b>23</b> Year <b>1957</b> a. m. <b>p.</b> m.					
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 <b>11-23-1957</b> to <b>11-23-1957</b> and last saw her/him alive on <b>8:35 11-23</b> Death occurred at <b>8:35 pm</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Robert J. Sawan</b> (Degree or title)		22b. ADDRESS <b>601 S. Brentwood Clayton</b>	22c. DATE SIGNED <b>11-23-57</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-26-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>		
24. FUNERAL DIRECTOR <b>Jos. W. Clark</b> ADDRESS <b>F.H. 1125 Hodiamont</b>		25. DATE RECD. BY LOCAL REG. <b>11-25-57</b>	26. REGISTRAR'S SIGNATURE <b>Herbert R. Donche MD</b>		

(Licensed Embolmer's Statement on Reverse Side)

acc

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..... *Alfred J. Boedeker*  
Licensed Embalmer No. *260*

P. O. Address *112 Hudson*

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