

FILED JAN 28 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2195

STATE FILE NUMBER

Registration District No. 257 Primary Registration District No. 5880 Registrar's No. 1

300  
1-57

4

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 <u>Osage</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>Crawford Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</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>Linn Manor Rest Home</u>		Length of stay in 1b <u>2 years</u>	d. STREET ADDRESS (If outside, give location) <u>No. 2 Glenoak</u>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Stella</u> Middle <u>Kate</u> Last <u>Lloyd</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>21,</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 10, 1887</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>11</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OWN HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>John G. Frohoff</u>		13b. MOTHER'S MAIDEN NAME <u>Josephine Walthers</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>495 22 8800</u>	17. INFORMANT <u>Mrs Russel Beal</u> Address		
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>Medullary Failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerosis, cerebral</u> DUE TO (c) <u>Hypertensive heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
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.) <u>443X</u>		
20c. TIME OF INJURY Hour <u>7:05 PM</u> Month, Day, Year <u>1-21-58</u> a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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>7-5-56</u> to <u>1-21-58</u> and last saw her <u>him</u> alive on <u>1-15-58</u> Death occurred at <u>7:05 PM 1-21-58</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Arnold W. Baldwin D.O.</u>			22b. ADDRESS <u>Linn</u>		22c. DATE SIGNED <u>1-22-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <u>St. Calvary</u>		23d. LOCATION (City, town, or county) (State) <u>St Louis Mo</u>
24. FUNERAL DIRECTOR <u>Clyde Morton</u>		ADDRESS <u>Linn Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Jan. 25-1958</u>	26. REGISTRAR'S SIGNATURE <u>T. A. ...</u>

JAN 29 1958  
FEB 5 1958

**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 *Almon M. Waters* .....

Licensed Embalmer No. *4125* .....

P. O. Address *Lebanon, Tenn* .....

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.