

Health, Welfare, Public Service

300  
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JAN 17 1958

2891

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003**

Registrar's No. **185**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis,</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
08. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Deacones Hosp.</b>		Length of stay in lb <b>3 days</b>	15 <sup>4</sup> STREET ADDRESS <b>5000 So. Broadway</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>J.</b> Last <b>FLATTEN</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>6,</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 8, 1911</b> 9. AGE (In years (last birthday)) <b>46</b> IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Yard Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Geitner-Home</b>	11. BIRTHPLACE (City and state or country) <b>North Dakota</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Joseph Flatten</b>		14. MOTHER'S MAIDEN NAME <b>Fanny Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes. W.W.#2</b>		16. SOCIAL SECURITY NO. <b>501-05-6667</b>	17. INFORMANT Address <b>Vivian Holstenson, North Dakota</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>Lobar Pneumonia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Diabetes Mellitus</b> DUE TO (c) <b>490x</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)			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 <input type="checkbox"/> a. m. <input type="checkbox"/> Month, Day, Year p. 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>30</b> , to _____ and last saw her/him alive on _____ Death occurred at <b>11 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree of (M.D.)) <b>James M. Kelly, M.D.</b>		22b. ADDRESS <b>1300 Clark</b>	22c. DATE SIGNED <b>1-8-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>?</b>	23c. NAME OF CEMETERY OR CREMATORY <b>?</b>	23d. LOCATION (City, town, or county) (State) <b>Wahpeton, North Dakota</b>
24. FUNERAL DIRECTOR ADDRESS <b>Fendler Und.Co. 7420 Michigan Ave.</b>		25. DATE RECD. BY LOCAL REG. <b>JAN 8 '58</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b> <b>msb</b>

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 *W. G. Peterson*

Licensed Embalmer No. *37*

P. O. Address *7420 Michigan*

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.