

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-020355  
STATE FILE NUMBER

FILED JUN 9 1958 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1473

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>Ste. Genevieve</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>Ste. Genevieve</b> 0951 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 County Hospital</b>		Length of stay in 1b <b>DOA</b>	d. STREET ADDRESS (If outside, give location) <b>7th St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Isaac</b> Last <b>McDaniel</b>			4. DATE OF DEATH Month <b>June</b> Day <b>1</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 type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 24, 1903</b>	9. AGE (In years last birthday) <b>55</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
-----------------------	----------------------------------	---	---	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lime Worker</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Lime Industry</b>	11. BIRTHPLACE (City and state or country) <b>Illinois</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
---	---	---	---

13a. FATHER'S NAME <b>Isaac B. McDaniel</b>	13b. MOTHER'S MAIDEN NAME <b>Cora Graff</b>	14. NAME OF HUSBAND OR WIFE <b>Lavada</b>
--	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>490-01-9561</b>	17. INFORMANT <b>Rowena Kinder, Fredericktown, Mo.</b> 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) <b>unknown natural cause</b>		INTERVAL BETWEEN ONSET AND DEATH <b>unk</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____	DUE TO (c) <b>7954</b>	
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"/> <b>2</b>

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 <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 <b>St. Francois Co., Mo.</b>	COUNTY _____ STATE _____
---	--	--	--------------------------

21. I attended the deceased from \_\_\_\_\_, to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Herbert R. Domke, MD., Local Registrar</b>	22b. ADDRESS <b>651 S. Brentwood, Clayton, Mo.</b>	22c. DATE SIGNED <b>6/4/58</b>
---	---	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>6-1-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Hill Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Francois Co., Mo.</b>
---	----------------------------	---	---

24. FUNERAL DIRECTOR <b>Albert H. Hoppe, 4700 Washington Blvd.</b>	ADDRESS _____	25. DATE RECD. BY LOCAL REG. <b>6-2-58</b>	26. REGISTRAR'S SIGNATURE <b>Herbert R. Domke MD.</b>
---	---------------	---	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JUN 1 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 *Elmer R. Sadurel*

Licensed Embalmer No. 4077 P. O. Address *St. Louis*

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.