

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002946
STATE FILE NUMBER
2 968
Registrar's No.

FILED FEB 10 1959

Registration District No.

Primary Registration District No.

Registrar's No.

300

-57

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1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		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 Hospital		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 227 2835a Cherokee St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Frances L. Francois			4. DATE OF DEATH Month Day Year Jan. 26, 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 7, 1873	9. AGE (In years last birthday) 85	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) housekeeping		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME John Rollberg		13b. MOTHER'S MAIDEN NAME Catherine Haupt		14. NAME OF HUSBAND OR WIFE John B. Francois	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Edward Rollberg-East St. Louis, Illinois Address	
18. CAUSE OF DEATH (Enter only one cause for line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Arterio Sclerosis,</i> <i>Fracture of Left Hip</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Fracture of Left Hip</i> DUE TO (c) <i>E903.7 44</i>				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) <i>Suffered in fall to fracture at Chronic Hospital on January</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I for fatal system 18) <i>at Chronic Hospital on January</i>			
20c. TIME OF INJURY Hour Month, Day, Year a.m. 1 18 59 p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bldg., etc.) <i>131 Ave</i>			
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <i>St. Louis Mo</i>		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 (Degree or Title) <i>John B. Francois</i>			22b. ADDRESS <i>1200 Clair</i>		22c. DATE SIGNED <i>1/27/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>Jan. 29, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Park Lawn Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis County, Missouri</i>	
24. FUNERAL DIRECTOR Wacker-Helderle-3634 Gravois Ave.			25. DATE RECD. BY LOCAL REG. <i>JAN 28 '59</i>		26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Frank J. Hand*.....
Licensed Embalmer No. *2645*.....
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.