Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002949

STATE FILE NUMBER 2 1064

FILED FEB 10 1959

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Chronic Hosp. — Length of stay in 1b: 6yr 5mo 5dys

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY:
c. CITY OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 2029a Bremen — Reside on Farm Yes ☐ No ☐

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3. NAME OF DECEASED (Type or print): First: Mary — Middle: — Last: Fraze

4. DATE OF DEATH: Month Jan. Day 28, Year 1959

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Sept. 25 1879

9. AGE (In years last birthday): 79 — 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): self

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): St. Louis, Mo.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: John Gafney

13b. MOTHER'S MAIDEN NAME: Susan Lynch

14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mrs. Agnes Coffey — Address: 5559 Waterman

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial Infarction	11 days.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Coronary Thrombosis	11 days
DUE TO (c)	Arteriosclerotic Heart Disease	6 1/2 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Generalized Arteriosclerosis - 6 1/2 yrs.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.): 420.0

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 Aug. 19, 1952, to Jan. 28, 1959 and last saw her/him alive on Jan. 28, 1959. Death occurred at 8:00 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John W. Beckham, M.D.

22b. ADDRESS: 5800 Arsenal

22c. DATE SIGNED: 1/29/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 1/31/59

23c. NAME OF CEMETERY OR CREMATORY: Calvary

23d. LOCATION (City, town, or county) (State): St. Louis Mo.

24. FUNERAL DIRECTOR: Jos. A. Howard — ADDRESS: 1619 So. Grand

25. DATE RECD. BY LOCAL REG.: JAN 30 '59

26. REGISTRAR'S SIGNATURE: Earl Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 .....

Licensed Embalmer No. 4,108

P. O. Address .....

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.