

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007032

STATE FILE NUMBER  
2 1328

Health,  
Welfare  
Public  
Service

300  
1-56

49  
35  
Diseases in Part I must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Registration District No. .... Primary Registration District No. ....

**FILED MAR 2 1959**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN St. Louis Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Hazelwood 4060 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION Home of Aged 3225 N. Florissant Length of stay in 1b 3 years		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> 404 Fee Fee Hill Drive	
3. NAME OF DECEASED (Type or print) First Middle Last Frank Joseph Denk			4. DATE OF DEATH Month Day Year Feb. 6th. 1959
5. SEX M. <input checked="" type="checkbox"/> W. <input type="checkbox"/>	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-24-1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	9. AGE (In years last birthday) 66 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) St. Anthony Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Valentine Denk		14. MOTHER'S MAIDEN NAME Barbara Lethig	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Address Bertha Shuey 404 Fee Fee Hill Drive			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cardio-vascular-renal disease 442x DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 8 days. ? ! !
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"/>
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 or Part II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a. m. 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 Jan. 30, 1959 to Feb 6, 1959 and last saw him alive on Feb 4, 1959. Death occurred at 8 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (In case of male) Bernard H. Doherty M.D.		22b. ADDRESS 2435 N. Grand Blvd	22c. DATE SIGNED 2-6-59
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 2-9-1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Missouri
24. FUNERAL DIRECTOR ADDRESS Arthur J. Donnelly 3840 Lindell Blvd.		25. DATE RECD. BY LOCAL REG. FEB - 1959	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

(H.T.)

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. 76

P. O. Address 3840 Jun

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.