

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014806

FILED MAY 1 1959

STATE FILING NUMBER 2762

Registration District No. Primary Registration District No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		Length of stay in 1b 15 days	d. STREET ADDRESS (If outside, give location) 5527 Bancroft
3. NAME OF DECEASED (Type or print) First Middle Last Frederick W. Christman			4. DATE OF DEATH Month Day Year 3 17 1959
5. SEX Male	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 Dec. 28, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Railroad Man-Mo. Pac.R.R.Co. Ill. Decatur		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 70
13a. FATHER'S NAME August Christman		13b. MOTHER'S MAIDEN NAME Louise Zelneck	12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No None		16. SOCIAL SECURITY NO. 702-16-3691	14. NAME OF HUSBAND OR WIFE Late Goldie Christman
17. INFORMANT Edwin L. Walbridge 5527 Bancroft Av.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Metastatic C.A.</i> DUE TO (b) _____ DUE TO (c) <i>Epidermoid C.A. of Lung</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>163x</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 mo.</i> <i>2 yrs.</i>
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 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 <u>3-2-59</u> to <u>3-17-59</u> and last saw her/him alive on <u>3-17-59</u> Death occurred at <u>6:30 a.m.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>John W. Beckham, M.D.</i>		22b. ADDRESS <i>5800 Arsenal</i>	22c. DATE SIGNED <i>3/17/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Mar. 19, 1959	23c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR Kriegshauser 4228 S.Kingshighway		25. DATE RECD. BY LOCAL REG. MAR 18 '59	26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

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 *Richard W. Storey*

Licensed Embalmer No. *4007*
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.