Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-014964
STATE FILE NUMBER

FILED MAY 1 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 2763

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St.Louis — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 1704 Nicholson Pl — Length of stay in 1b
d. STREET ADDRESS (If outside, give location): 1704 Nicholson — Reside on Farm: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St.Louis — Inside Limits: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: Frank — Middle: J — Last: Flaherty

4. DATE OF DEATH: Month: Mar — Day: 18 — Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 3 1874
9. AGE (In years last birthday): 84 — 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): Receving clerk
10b. KIND OF BUSINESS OR INDUSTRY: Hotel
11. BIRTHPLACE (City and state or country): St.Louis Mo
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Patrick Flaherty
13b. MOTHER'S MAIDEN NAME: Margaret Unknown
14. NAME OF HUSBAND OR WIFE: Josephine Russell

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.: 493 07 5441
17. INFORMANT: Josephine Flaherty — Address: 1704 Nicholson Pl

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Old Fracture of right hip
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Generalized Arterio sclerosis
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 450.0

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.): Slipped in Fall on ice in February of 1956, at Nicholson and Lafayette
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.): 23 Street
20f. CITY, TOWN, OR LOCATION: St Louis — COUNTY — STATE: Mo

21. I attended the deceased from ..... to ..... and last saw her/him alive on .....
Death occurred at 237 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Regan M. Smith (Degree or title) Deputy Coroner
22b. ADDRESS: 1300 Clark
22c. DATE SIGNED: 3/18/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Mar 19 59
23c. NAME OF CEMETERY OR CREMATORY: Calvary
23d. LOCATION (City, town, or county) (State): St.Louis Mo

24. FUNERAL DIRECTOR: E.J.Schnur — ADDRESS: 3125 Lafayette
25. DATE RECD. BY LOCAL REG.: MAR 18 '59
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Thomas R. Lenwick

Licensed Embalmer No. 3793

P. O. Address 3125 Lafayette

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.