

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015780

STATE FILE NUMBER

FILED MAY 1 1959 Registration District No. Primary Registration District No. Registrar No. 3527

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>ST. LOUIS</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>ALEXIAN BROTHERS HOSP.</i>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <i>3924 S GRAND</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>FRANK J STANZE</i>			4. DATE OF DEATH Month Day Year <i>APRIL 6 1959</i>
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1879 NOV 4, 1880</i> 9. AGE (In years, months, & days) <i>76 79</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>PHYSICIAN</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>ST. LOUIS, MO.</i> 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13a. FATHER'S NAME <i>NOT KNOWN</i>		13b. MOTHER'S MAIDEN NAME <i>NOT KNOWN</i>	14. NAME OF HUSBAND OR WIFE <i>PEARL</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT Address <i>PEARL STANZE 3924 S GRAND</i>
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>Cerebral Thrombosis</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Arteriosclerosis General</i> DUE TO (c) <i>332X</i>			INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i> <i>UNK</i>
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 type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury and PART I of item 18.) <i>ITEM 8, 9 CORRECTED</i>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		BY: 1. AFFIDAVIT OF <i>Funeral Director</i> 2. DOCUMENT <i>of Death Comm. dated 2-3-1938</i>	
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 <i>Dec 20-58</i> , to <i>Apr 6</i> and last saw her alive on <i>Apr 5-59</i> Death occurred at <i>2 am</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Robert S Warner M.D.</i> (Degree or title)		22b. ADDRESS <i>818 Olive St St Lmo</i>	22c. DATE SIGNED <i>4/7/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	23b. DATE <i>4/9/1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>SUNSET BURIAL PARK</i>	23d. LOCATION (City, town, or county) (State) <i>AFFTON, MO.</i>
24. FUNERAL DIRECTOR <i>J L ZIEGENHEIN & SONS 7027 GRAVOIS</i>		25. DATE RECD. BY LOCAL REG. <i>APR 9 '59</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith M.D.</i>

(Licensed Embalmer's Statement on Reverse Side)

M. G. B.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

with, welfare, public service

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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 *E. P. Kidwell*

Licensed Embalmer No. *3877*

P. O. Address *7027*

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.