

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019290

STATE FILE NUMBER

Registration No. 5358

Registration District No. Primary Registration District No.

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only)
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN
d. STREET ADDRESS

St. Louis
Missouri
St. Louis
Lutheran Hospital
2 days
6812 Hancock

3. NAME OF DECEASED (Type or print)
First Middle Last
Frank J. Jasper, Jr.

4. DATE OF DEATH
Month Day Year
June 4, 1959

5. SEX
Male

6. COLOR OR RACE
Caucasian

7. MARRIED NEVER MARRIED
WIDOWED DIVORCED

8. DATE OF BIRTH
March 12, 1953

9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS
6 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Student

10b. KIND OF BUSINESS OR INDUSTRY
Epiphany School

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

12. CITIZEN OF WHAT COUNTRY?
USA

13a. FATHER'S NAME
Frank J. Jasper, Sr.

13b. MOTHER'S MAIDEN NAME
Agnes A. Krekel

14. NAME OF HUSBAND OR WIFE
Never married

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

16. SOCIAL SECURITY NO.
None

17. INFORMANT
Frank J. Jasper, Sr. 6812 Hancock, St. Louis

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) asphyxiation of vomitus
DUE TO (b)
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
tonsilectomy - 6-3-59 5101

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.)

20c. TIME OF INJURY
Hour Month, Dc., Year
a.m. p.m. 6-4-59

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.)
Lutheran Hospital St. Louis

20f. CITY, TOWN, OR LOCATION COUNTY STATE
St. Louis Mo

21. I attended the deceased from Death occurred on June 4 1959 at 2:00 A.M.
and last saw her alive on June 3 1959 on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)
Dr. Kunkle M.D.

22b. ADDRESS
4075 S Grand

22c. DATE SIGNED
6/4/59

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

23b. DATE
6/6/1959

23c. NAME OF CEMETERY OR CREMATORY
St. Peter and Paul

23d. LOCATION (City, town, or county) (State)
2030 Gravois, St. Louis, Missouri

24. FUNERAL DIRECTOR ADDRESS
HOFFMEISTER COLONIAL MORTUARY
6464 CHIPPEWA ST. ST. LOUIS, MISSOURI

25. DATE RECD. BY LOCAL REG.
JUN 4 '59

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

USE ONLY BLACK INK OR RIBBON. TYPE 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 *John J. Blinn*
Licensed Embalmer No. *4194*
P. O. Address *St. Louis*

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.