

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019292

STATE FILE NUMBER

2 4559

FILED MAY 25 1959

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

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) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN University City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 6944 Roberts Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last FRANK XAVIER JENNEMANN			4. DATE OF DEATH Month Day Year May 8 1959		
5. SEX male <input checked="" type="checkbox"/>	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1885		9. AGE (In years last birthday) 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired-photo engraver		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Charles T. Jennemann		13b. MOTHER'S MAIDEN NAME Roseni Meier		14. NAME OF HUSBAND OR WIFE Hazel Little Jennemann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 488-01-3128	17. INFORMANT Address Mrs. Hazel Jennemann, 6944 Roberts Ave.		
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 Emboli multiple recan</i> DUE TO (b) <i>Vein Thrombosis at leg</i> DUE TO (c) <i>466x</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Arteriosclerotic Heart Disease complete</i>					INTERVAL BETWEEN ONSET AND DEATH <i>2w</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 <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>May 5</i> to <i>5-8-59</i> and last saw her alive on <i>5-8-59</i> Death occurred at <i>9:40 p</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>M. Kimmelman M.D.</i>			22b. ADDRESS <i>1005 Ogden St. Louis</i>		22c. DATE SIGNED <i>5-9-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 5-11-1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or country) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR C. R. Lupton & Sons-7233 Delmar			25. DATE RECD. BY LOCAL REG. <i>May 9 1959</i>	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i> <i>m j B.</i>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard forms. All diseases in Part I must be causally related.

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Health, Welfare
Public Service

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 *Clarence A. Murray*

Licensed Embalmer No. *40116*
P. O. Address *St. Louis, Mo.*

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.