

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022888

STATE FILE NUMBER

Registration No. 5414

FILED JUN 18 1959

Registration District No.

Primary Registration District No.

Registration No.

300
1-57
2
0

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence prior admission) a. STATE MO b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis | | c. CITY OR TOWN St Louis | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5250 Loughborough | | d. STREET ADDRESS (If outside, give location) 5250 Loughborough | |
| Length of stay in lb | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |

| | | | | | |
|---|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last Charles E Frank | | | 4. DATE OF DEATH Month Day Year June 4, 1959 | | |
|---|--|--|--|--|--|

| | | | | | | |
|-------------|------------------------|---|----------------------------------|---------------------------------|--------------------------------|--------------------------------|
| 5. SEX male | 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 Jan 23, 1889 | 9. AGE (In years) 70 (birthday) | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
|-------------|------------------------|---|----------------------------------|---------------------------------|--------------------------------|--------------------------------|

| | | | |
|--|---|--|-------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during preceding working life, even if retired) Retired | 10b. KIND OF BUSINESS OR INDUSTRY Police Officer | 11. BIRTHPLACE (City and state or country) St Louis Mo. | 12. CITIZEN OF WHAT COUNTRY? USA |
|--|---|--|-------------------------------------|

| | | |
|------------------------------------|--|---|
| 13a. FATHER'S NAME Joseph Frank | 13b. MOTHER'S MAIDEN NAME Mary Schiller | 14. NAME OF HUSBAND OR WIFE Sophia T Frank |
|------------------------------------|--|---|

| | | |
|--|--|---|
| 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. 486-40-6922 | 17. INFORMANT Address Sophia T Frank 5250 Loughborough |
|--|--|---|

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the aesophagus | | INTERVAL BETWEEN ONSET AND DEATH 2 years |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | |
| 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 in PART I or PART II of item 18.) 150x |
| 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 _____ to _____ and last saw him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

| | | | |
|---|-------------------|--|----------------------------|
| 22a. SIGNATURE John H. Ziegenhein M.D. | (Degree or title) | 22b. ADDRESS 1504 So Grand St Louis | 22c. DATE SIGNED 6-5-59 |
|---|-------------------|--|----------------------------|

| | | | |
|---|--------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | 23b. DATE June 8 1959 | 23c. NAME OF CEMETERY OR CREMATORY Lakewood Park | 23d. LOCATION (City, town, or county) (State) St Louis Missouri |
|---|--------------------------|---|--|

| | | | |
|---|-------------------------|---|--|
| 24. FUNERAL DIRECTOR J L Ziegenhein & Sons | ADDRESS 7027 Gravois | 25. DATE RECD. BY LOCAL REG. JUN 8 '59 | 26. REGISTRAR'S SIGNATURE Karl Smith M.D. |
|---|-------------------------|---|--|

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Donald Benz*

Licensed Embalmer No. *4863*
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.