URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS DEC 7 1959

59-041737

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210929

ENDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MO.
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. LOUIS CITY HOSP. #1
Inside Limits: 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 ☐
d. STREET ADDRESS (If outside, give location): 2826 Arsenal St.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First PRESTON Middle J. Last DE FRENNE

4. DATE OF DEATH: Month NOV. Day 24, Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 8/9/1898

9. AGE (last birthday): 61

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.

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

10b. KIND OF BUSINESS OR INDUSTRY: Shoes

11. BIRTHPLACE (City and state or country): Prairie Du Rocher, Ill.

12. CITIZEN OF WHAT COUNTRY: U.S.

13a. FATHER'S NAME: Joseph DuFrenne

13b. MOTHER'S MAIDEN NAME: Agnes Longlois

14. NAME OF HUSBAND OR WIFE: Bertha

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

16. SOCIAL SECURITY NO.: 318-14-1474

17. INFORMANT: Bertha DeFrenne, Address: 2826 Arsenal St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intra Cerebral hemorrhage
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 33/x
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)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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 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.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 11/15/59, to 11/24/59 and last saw her/him alive on 11/24/59

Death occurred at 12:55P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Robert K. Lane MD.

22b. ADDRESS: 1515 LAFAYETTE AVE

22c. DATE SIGNED: 11/24/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 11-28-59

23c. NAME OF CEMETERY OR CREMATORY: St. Joseph Cemetery

23d. LOCATION (City, town, or county) (State): Prairie Du Rocher, Ill.

24. FUNERAL DIRECTOR: Albert H. Hoppe, Inc.

ADDRESS: 4700 Washington Blvd.

25. DATE RECD. BY LOCAL REG.: NOV 25 1959

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

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Harvey Kahler

Licensed Embalmer No. 4596

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com
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.