URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

59-042913

FILED, VS NOV 3 0 1959

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2903

ENDED

1. PLACE OF DEATH
a. COUNTY Robert Koch Hospital
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Koch, Mo
Length of stay in 1b 81days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Robert Koch Hospital
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) 4411 Gibson Ave.
Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First FRANK Middle - Last KARL
4. DATE OF DEATH Month 10- Day 31- Year 59
5. SEX Male
6. COLOR OR RACE White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 11-15-88
9. AGE (last birthday) 70
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) Maintenance Man
10b. KIND OF BUSINESS OR INDUSTRY Janitor
11. BIRTHPLACE (City and state or country) Missouri
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Felix Karl
13b. MOTHER'S MAIDEN NAME Helena Dorlac
14. NAME OF HUSBAND OR WIFE Nil
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 489-40-9775
17. INFORMANT Records at Robert Koch Hospital Address

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) Peritonitis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Perforation of Duodenal Ulcer
DUE TO (c) 541.1
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)
T.T. Fracture of Left Femur
Stasis Dermatitis with Trophic Ulcer

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 (Give nature of injury in PART I or PART II of item 18.)
Fractured leg on 7-11-59
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 7-11-59
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.) Streets of City
20f. CITY, TOWN, OR LOCATION St. Louis COUNTY STATE

21. I attended the deceased from 8-11-59, to 10-31-59 and last saw her/him alive on 10-30-59
Death occurred at 1:53 A.M. 10-31-59 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Harold G. Russell MD (Degree or title)
22b. ADDRESS Robert Koch Hospital
22c. DATE SIGNED 10-31-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Nov.3,1959
23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery
23d. LOCATION (City, town, or county) St. Louis Co. Mo. (State)

24. FUNERAL DIRECTOR Kriegshauser ADDRESS 4228 S.Kingshighway
25. DATE RECD. BY LOCAL REG. 11-2-59
26. REGISTRAR'S SIGNATURE John C. Murphy 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 m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 3024

P. O. Address_____

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