

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 1 1960

~~212186-59-047047~~

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **212186-59-047047** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>Olivette</b>	
Length of stay in 1b <b>D.O.A.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Baptist Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>#15 Stacy Drive</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>Frank Morton Sskwor</b>			4. DATE OF DEATH Month Day Year <b>December 31, 1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-2-1903</b>	9. AGE (last birthday) <b>56</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Professor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Teaching</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Joseph A. Sskwor</b>		13b. MOTHER'S MAIDEN NAME <b>Birdie Barlow</b>		14. NAME OF HUSBAND OR WIFE <b>Dorothy Sskwor</b>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>491-26-3812</b>	17. INFORMANT Address <b>Dorothy Sskwor, #15 Stacy Drive</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
IMMEDIATE CAUSE (a)	<b>Acute Coronary occlusion</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<b>Arteriosclerotic heart disease</b>	
DUE TO (b)	<b>4200</b>	<b>3 yr</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)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year				

20d. INJURY OCCURRED WHILE AT WORK <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 <b>1933</b> to <b>death</b> and last saw <sup>him</sup> alive on <b>29 Dec 1959</b> Death occurred at <b>3:40</b> <b>A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <b>Paul R. Whitener</b> (Degree or title) <b>M.D.</b>	22b. ADDRESS <b>2403 Brown Rd. St. Louis (14) Mo</b>	22c. DATE SIGNED <b>31 Dec 59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>1-2-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hiram Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Creve Coeur, Missouri</b>
24. FUNERAL DIRECTOR <b>Baumann Bros. Inc. Overland, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>DEC 31 1959</b>	26. REGISTRAR'S SIGNATURE <b>Road Smith, M.D.</b>	

DOCUMENT

MEDICAL CERTIFICATION

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

*David C. Gel*

Licensed Embalmer No. 3454

P. O. Address Parlan

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