

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH -60-039738

FILED VS OCT 26 1960

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STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Park Lane		d. STREET ADDRESS (If outside, give location) 1419 N. 8th St.	

3. NAME OF DECEASED (Type or print) First Elizabeth Middle Frank Last			4. DATE OF DEATH Month 10 Day 14 Year 60		
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-20-1882	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME George Redmann	13b. MOTHER'S MAIDEN NAME Katherine	14. NAME OF HUSBAND OR WIFE Thomas
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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.	17. INFORMANT Harry Frank 7919 Colleen Dr.
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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
IMMEDIATE CAUSE (a) Bronchial Pneumonia		3 days
DUE TO (b) Cardiac Failure		1 day
DUE TO (c) Senility, Arteriosclerosis, general		6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition shown in PART I (a) Obesity		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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.)
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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
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21. I attended the deceased from **15 Sept 60** to **17 Oct 60** and last saw her alive on **14 Oct 60**
Death occurred at **2 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Leonard Stein M.D.	22b. ADDRESS 1918 East Greer St.	22c. DATE SIGNED 15 Oct 60
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23a. BURIAL OR CREMATION REMOVAL (Specify) Burial	23b. DATE 10-17-60	23c. NAME OF CEMETERY OR CREMATORY Calvary	23d. LOCATION (City, town, or county) St. Louis, Missouri
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24. FUNERAL DIRECTOR ST. LOUIS FUNERAL HOME 2205 ST. Louis Ave.	25. DATE RECD. BY LOCAL REG. OCT 15 1960	26. REGISTRAR'S SIGNATURE Leon Smith, M.D.
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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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John J. Haine

Licensed Embalmer No. 4108

P. O. Address St. Louis

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