

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-016060

STATE FILE NUMBER

AMENDED

Registration District No. 347 Primary Registration District No. 541 Registrar's No. 1237

1. PLACE OF DEATH  
 a. COUNTY ST. LOUIS  
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CLAYTON Length of stay in 1b 2 WEEKS  
 c. CITY OR TOWN WELLSTON Inside Limits Yes  No   
 d. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CO HOSPITAL Inside Limits Yes  No   
 e. STREET ADDRESS (If outside, give location) 6160 BERTHA AVE Reside on Farm Yes  No

3. NAME OF DECEASED First Middle Last FRANK G ULRICH 4. DATE OF DEATH Month 5 Day 1 Year 61  
 5. SEX MALE 6. COLOR OR RACE WHITE 7. Married  Never Married  Widowed  Divorced  8. DATE OF BIRTH 12-1-29 9. AGE (last birthday) 82  
 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAIL CLERK 10b. KIND OF BUSINESS OR INDUSTRY RETIRED 14 YRS 11. BIRTHPLACE (City and state or country) NEW YORK - N.Y. 12. CITIZEN OF WHAT COUNTRY U.S.A.  
 13a. FATHER'S NAME FRANCIS X ULRICH 13b. MOTHER'S MAIDEN NAME LIZZIE CROWE 14. NAME OF HUSBAND OR WIFE JOHANNA ULRICH  
 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. NONE 17. INFORMANT FRANK L ULRICH Address 10750 NIBLIC DRIVE

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

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Loeemias arthritis & esophageal varices  
 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 4-15-61 to 5-1-61 and last saw her/him alive on 5-1-61  
 Death occurred at 8:00 P on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE Robert L. Howe MD (Degree or title) 22b. ADDRESS 6015a. Brentwood Clayton 22c. DATE SIGNED 5/2/61  
 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE MAY 4-1961 23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEMETERY 23d. LOCATION (City, town, or county) ST. LOUIS COUNTY MISSOURI  
 24. FUNERAL DIRECTOR SHEPARD FUNERAL HOME ADDRESS 1167 HAMILTON AVE 25. DATE RECD. BY LOCAL REG. 5-3-61 26. REGISTRAR'S SIGNATURE James M. Murphy M.D.

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

**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

~~on~~ \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Lawrence O. Herling

Licensed Embalmer No. 4979

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.