MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-030437
STATE FILE NUMBER

AMENDED

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 210

FILED SEP 1 1961

1. PLACE OF DEATH
a. COUNTY: St Charles
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St Charles — Length of stay in 1b:
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St Joseph's — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo b. COUNTY: St Louis
c. CITY OR TOWN: Florissant — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 415 No. Lafayette — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Robert Middle: LeRoy Last: Frantz
4. DATE OF DEATH: Month: Aug Day: 22 Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 8-21-61
9. AGE (last birthday) — IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HR: Hours: 20 Min.: 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and state or country): St. Charles, Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Robert LeRoy Frantz
13b. MOTHER'S MAIDEN NAME: Marion Theresa Rehlmann
14. NAME OF HUSBAND OR WIFE: —
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Robert L. Frantz, 415 No. Lafayette Florissant, Mo.

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): Hyaline Membrane Disease. — INTERVAL BETWEEN ONSET AND DEATH: 20 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (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): Prematurity
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 12:30 PM 8-21-61, to 6:45 AM 8-22 and last saw her alive on 6:45 AM 8-22-61
Death occurred at 6:45 AM 8-22 m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): N. C. Hammes M.D.
22b. ADDRESS: 207 N. 5th St.
22c. DATE SIGNED: 8/23/61
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 8-23-61
23c. NAME OF CEMETERY OR CREMATORY: Sacred Heart Cemetery
23d. LOCATION (City, town, or county) (State): Florissant, Mo.
24. FUNERAL DIRECTOR ADDRESS: The Florissant Mortuary, Florissant, Mo.
25. DATE RECD. BY LOCAL REG.: Aug 22-61
26. REGISTRAR'S SIGNATURE: Marcella Wilson

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

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, or by _____, Student Embalmer No._____ working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed [signature]

Licensed Embalmer No. 4966

P. O. Address Florissant, 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.