THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24544

FILED AUG 3 1953

BIRTH NO. _____ REG. DIST. NO. 137 PRIMARY REG. DIST. NO. 5519 Registrar's No. 176

1. PLACE OF DEATH
a. COUNTY Henry
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural White Oak
c. LENGTH OF STAY (In this place) Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) on Lucas

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Missouri
b. COUNTY Henry
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural White Oak
d. STREET ADDRESS (If rural, give location) on Lucas 4420

3. NAME OF DECEASED (Type or Print) a. (First) Frank b. (Middle) c. (Last) Helm

4. DATE OF DEATH (Month) (Day) (Year) 7-27-1953

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH Aug 10 1892

9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 1 hr.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and State or Foreign Country) Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME John Helm

13b. MOTHER'S MAIDEN NAME Anna Westmeyer

14. NAME OF [redacted] WIFE Jessie Mae Helm

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War II

16. SOCIAL SECURITY NO. 496-16-8528

17. INFORMANT'S SIGNATURE OR NAME Jessie Mae Helm **ADDRESS** Urich Mo

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hour

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. 4201

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19 53 *to* _____, 19 53 *that I last saw the deceased alive on* April, 19 53, *and that death occurred at* 8:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) James O. Smith MD

23b. ADDRESS Clinton, Mo.

23c. DATE SIGNED 7-28-53

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7-29-53

24c. NAME OF CEMETERY OR CREMATORY Urich Cemetery

24d. LOCATION (City, town, or county) (State) Urich Mo

DATE REC'D BY LOCAL REG. Aug. 1 - 53

REGISTRAR'S SIGNATURE Florence Adair

25. FUNERAL DIRECTOR'S SIGNATURE Sichman-Dunning **ADDRESS** Clinton Mo

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

AUG 17 19[illegible]

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 .....
Student Embalmer

Signed R. L. Dunaway

Licensed Embalmer No. 4710

P. O. Address Clayton, [illegible]

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 this body is not embalmed, fact should be so stated above.