Health,
. Welfare
Public
Service

300
1-57

SL-19825
XC-UNKNOWN

FILED JUN 4 1959

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-018951
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2.5017

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MO. — Inside Limits: Yes [X] No [ ]

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: VAH, 915 NO. GRAND — Length of stay in 1b: 23 DAYS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI — b. COUNTY

c. CITY OR TOWN: ST. LOUIS — Inside Limits: Yes [X] No [ ]

d. STREET ADDRESS (If outside, give location): 3203 IVANHOE AVE. — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First FRANK — Middle S. — Last BISCAN

4. DATE OF DEATH: Month 5 — Day 22 — Year 59

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
MALE	WHITE	MARRIED [X]	3/13/20	39		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
CONSTRUCTION WORKER		MT. OLIVE, ILLINOIS	U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
MATT BISCAN, SR.	CAROLINE PAUR	MARIE BISCAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
YES	WW-II	709-07-5462	VAH, 915 NO. GRAND AVE., ST. LOUIS, MO.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 3 WEEKS

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): ARTERIOSCLEROTIC HEART DISEASE — 3 WEEKS

DUE TO (c): _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

420-0

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

MEDICAL CERTIFICATION

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ] NONE [ ]

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. VA attended the deceased from 4/29/59 to 5/22/59 and last saw ~~him~~ alive on 5/22/59
Death occurred at 3:44 PM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Leo T. Neu, Jr. M.D. (Degree or title) M.D.

22b. ADDRESS: VAH, ST. LOUIS, MO.

22c. DATE SIGNED: 5/22/59

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Removal	5/25/59	National Cem.	Jefferson Bks. Mo

24. FUNERAL DIRECTOR ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Edward Fendler 5611 South Grand Blvd.	MAY 24 '59	Hoard Smith . M. D.

(Licensed Embalmer's Statement on Reverse Side)

M. D. 13.

USE ONLY BLACK INK OR RIBBON TYPEWRITER IF POSSIBLE
All diseases in Part I must be causally related.