

Reg. Dist. No. 392
 Primary Reg. Dist. No. 8187

DIVISION OF VITAL STATISTICS
 CERTIFICATE OF DEATH

State File No. 4501 3300 Indiana 15574
 Registrar's No. 1352

1. PLACE OF DEATH a. COUNTY Franklin		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Ohio b. COUNTY Franklin	
b. CITY (If outside corporate limits, write RURAL OR and give township) VILLAGE Columbus		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2594 N. 4th St.,		d. STREET (If rural, give location) ADDRESS 2594 N. 4th St.,	

3. NAME OF DECEASED (TYPE OR PRINT) a. (First) FRANK b. (Middle) E. c. (Last) GLEICH			4. DATE OF DEATH (Month) (Day) (Year) MAR 27-1949		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 7, 1894	9. AGE (In years last birthday) 55	Under 1 Year Months 0 Days 20	If Under 24 Hrs. Hours 0 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Railroad police	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Columbus, Ohio	12. CITIZEN OF WHAT COUNTRY? US
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13. FATHER'S NAME Gleich	14. MOTHER'S MAIDEN NAME
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes WW#1	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE <i>Mrs. Grace Gleich</i>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 60 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Thromboangitis Obliterans left leg		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 4591			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Hemorrhage			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION no surgery
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office building, forest, etc.)	21c. (CITY) VILLAGE, OR TOWNSHIP (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Feb. 28, 1945**, to **Mar 27, 1949**, and that death occurred at **6:15 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE R. W. Bonnell, M.D.	(Degree or title)	23b. ADDRESS Columbus Ohio	23c. DATE SIGNED 3-28-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3/30/49	24c. NAME OF CEMETERY OR CREMATORY St. Joseph	24d. LOCATION (City, town, or county) (State) Columbus Ohio
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BIRTH NO. Do not write in this space	NAME OF EMBALMER (LIC. NO.) Robert E. O'Shaughnessy 4946A
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DATE REC'D BY LOCAL REG. 2/29/49	REGISTRAR'S SIGNATURE <i>Les Wridell</i>	25. FUNERAL DIRECTOR'S SIGNATURE (LIC. NO.) <i>Harry O'Shaughnessy 1393</i>
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