

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

001 23 1935

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

28264

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis Mo** (No. **3561**), **Staska** St. Ward)

File No.....
Registered No. **7418**
St. Ward)

2. FULL NAME

Robert L. Frichie
(a) Residence, No. **3561 Staska** St., **15** Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Hildegard Frichie**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **July 8, 1870**

7. AGE YEARS **65** MONTHS **1** DAYS **23** If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **Broker**

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. **Flour**

10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Mass.**

13. NAME **William C. Frichie**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Boston Mass.**

15. MAIDEN NAME **Ann Cawling**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Nova Scotia**

17. INFORMANT **Mrs Hildegard Frichie**
(ADDRESS) **3561 Staska**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Valhalla Crematorium** DATE **9/2/35** 19.....

19. UNDERTAKER **Edith C. Emburster**
(ADDRESS) **4234 Manchester av.**

20. FILED **SEP - 3 1935** 19 **J. Bredeck**
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **late Aug 31** 19**35**

22. I HEREBY CERTIFY, That I attended deceased from **July 26**, 19**35**, to **Aug 29**, 19**35**. I last saw him alive on **Aug 29**, 19**35**. Death is said to have occurred on the date stated above, at **12:30 Am.**

The principal cause of death and related causes of importance were as follows:

Carcinoma of parotid (left) Date of onset

Other contributory causes of importance: **53**
cerebral metastasis

Name of operation **Removal of growth** Date of **1933**

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) **Louis T. Byars**, M. D.

(Address) **400 Metropolitan Bldg**

Dr. Brown
Byam