

AUG 14 1939

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

25610
Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 318
 (b) Township _____ Primary Registration District No. 8901 Registered No. 547
 (c) City SPRINGFIELD (d) Street No. 2018 N. PROSPECT St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

623 EDWARD T. FRICHETTE
 (a) Residence, No. 2018 N. PROSPECT St. (If nonresident, give city or town and State)

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 Martha J. Frichette
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 23-1885
 7. AGE YEARS 54 MONTHS 1 DAYS 13 If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. liquor cabinet
 9. Industry or business in which work was done, as saw mill, bank, etc. Shop.
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 1

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas

FATHER 13. NAME Stephen Frichette

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas

MOTHER 15. MAIDEN NAME Emma A. Baker

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Leiter S. Frichette
610 N. Dale

18. BURIAL, CREMATION, OR REMOVAL PLACE Knacks Creek Mo. DATE July 8, 1939

19. FUNERAL DIRECTOR (ADDRESS) W. H. Kautsky
Springfield, Mo.

20. FILED July 7, 1939 Chas. A. George
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-6-39, 19

22. I HEREBY CERTIFY, That I attended deceased from 6-7, 1939, to 7-1-39, 19

I last saw him alive on 7-5-39, 19 Death is said to have occurred on the date stated above, at 3:00 a.m.

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

Apoplexy (Right Hemisphere) Date of onset 6-5-39

Other contributory causes of importance:
Bronchial Pneumonia 7-4-39
Acute Heart Failure 7-3-39

Name of operation _____ Date of _____
 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) _____, M. D.

(Address) Chas. A. George
Springfield, Mo.

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.

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.

X