

FILED MAR 7 - 1940

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

7128

Do not use this space.

1. PLACE OF DEATH

(a) County Rafayette Registration District No. 460
 (b) Township Edwin Primary Registration District No. A274 Registered No. 10
 (c) City Higginsville (d) Street No. _____ 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

(a) Residence, No. 1 Higginsville Mo. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widowed
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr. 30 - 1862
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
77 87 7 8
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
 9. Industry or business in which work was done, as saw mill, bank, etc. Printer
 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) Cincinnati Ohio

FATHER 13. NAME Charles Frouchle

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER 15. MAIDEN NAME Mary Ludwig

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT (ADDRESS) Higginsville Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Higginsville DATE 2-11-1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Walter M. M... Higginsville Mo.

20. FILED Mar. 1 1940 T. J. Webb Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 8 1940

22. I HEREBY CERTIFY, That I attended deceased from Jan 1 1940 to Feb 8 1940
 Last saw him alive on Feb 8 1940 Death is said to have occurred on the date stated above, at 9:20 PM
 The principal cause of death and related causes of importance were as follows:

Coronary Occlusion
Hemiplegia
94

Date of onset
Feb 7 - 40Jan 15 - 40

Other contributory causes of importance:

Arteriosclerosis
Hypertension

Years
Years

Name of operation None Date of _____
 What test confirmed diagnosis? None Was there an autopsy? No

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? No

(Signed) Charles M. Webb M. D.

(Address) Higginsville, Mo.

RECEIVED

RECEIVED
District Health Officer No. 8
District File Number 315740
Date Filed -----

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 Roy F. Weigman
Licensed Embalmer No. 2883

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 7128

Registration District No. 460

Primary Registration District No. 4274

Registrar's No. 10

1. PLACE OF BIRTH:

(a) County Lafayette
(b) City or town Higginsville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... (Specify whether
years, months or days)

3. (a) **PRINCE** FULL NAME Charley L. Froesele

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year.....

7. Birth date of deceased..... (Month)..... (Day)..... (Year).....

8. AGE: Years 77 Months 7 Days 8 If less than one day..... hr..... min.

9. Birthplace..... (City, town, or county)..... (State or foreign country).....

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county)..... (State or foreign country).....

14. Maiden name.....

15. Birthplace..... (City, town, or county)..... (State or foreign country).....

16. (a) Informant C.F. Froesele Jr.

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) April 11-40 (b) Tessany Webb (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette
(c) City or town Higginsville
(If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

20. DATE OF DEATH: Month Feb day 8 year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on....., 19....., and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town)..... (County)..... (State).....

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?..... (Specify type of place)..... (e) Means of injury.....

23. Signature Ernest M. Moore (or other).....

Address Higginsville..... signed.....

SUPPLEMENTARY

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

MOTHER FATHER

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

S-7128