

REGISTRATION DISTRICT NO. **FILED MAR 7 1945**

PRIMARY REGISTRATION DISTRICT NO. **1002**

1. PLACE OF DEATH:

(a) County **JACKSON**

(b) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution **RESEARCH HOSPITAL O**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **12 DAYS**
(Specify whether years, months or days)

In this community **9 YEARS**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **JACKSON**

(c) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL")

(d) Street No. **3703 LOCUST STREET**
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)

If yes, name country **-----D**

3. (a) PRINT FULL NAME **JOSEPH PRICE FRERKING, JR.**

(b) If veteran, name war **NO**

(c) Social Security No. **NONE**

4. Sex **MALE** 5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **SINGLE**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **OCTOBER - 16 - 1930**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
14	4	0	hr. _____ min.

9. Birthplace: **DENMARK** **IOWA**
(City, town, or county) (State or foreign country)

10. Usual occupation: **SOPHOMORE**

11. Industry or business: **SOUTHWEST HIGH SCHOOL**

MOTHER FATHER

12. Name: **JOE PRICE FRERKING, SR.**

13. Birthplace: **Carder Mo**
(City, town, or county) (State or foreign country)

14. Maiden name: **Jenny JOHNSON**

15. Birthplace: **Marshall Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant: **Dr. Joe Frerking, Sr.**

(b) Address: **5953 Locust**

17. (a) Place: **burial** **(b) Date thereof:** **Feb 19 45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: **burial or cremation** **Not recorded**

18. (a) Signature of funeral director: **W. H. Newcomer, Sons**

(b) Address: **1401 BRUSH CREEK BLVD.**

19. (a) Date received local registrar: **2-19-45** **(b) Registrar's signature:** **D. E. Brown**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **FEB.** day **16TH** year **1945** hour _____ minute _____ P.M.

21. I hereby certify that I attended the deceased from **Oct. 6** 19**44** to **February 16** 19**45**

that I last saw him alive on **February 16** 19**45** and that death occurred on the date and hour stated above.

Immediate cause of death _____ **Craniopharyngioma** **Completed**

Due to **non malignant**

Due to **5622**

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

Major findings: **Craniopharyngioma** **PHYSICIAN**

Of operations _____

Of autopsy **Craniopharyngioma** **Underline the cause to which death should be charged statistically.**

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? _____ Means of injury _____

23. Signature: **Frank R. Leachner** (M. D. or other) **MA**

Address **1630 Proj. Bldg. C.C. Mo.** Date signed **2-17-45**

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

1630 Professional Body
2-6

John W. Johnson
John W. Johnson
K.C.

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 Emile W. Calhoun

Licensed Embalmer No. 3506

P. O. Address KC Mo

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, fact should be so stated above.