S. No. 2
DM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 23 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 12157

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1525

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: K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 mos. 19 days (Specify whether years, months or days)
In this community 20 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. 5006 Wabash (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: William Frick
3. (b) If veteran, name war: No
3. (c) Social Security No. 492-18-6437
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Divorced
6. (b) Name of husband or wife: Mary Frick
6. (c) Age of husband or wife if alive: -- years
7. Birth date of deceased: 3 (Month) 13 (Day) 1900 (Year)

8. AGE: Years 45 Months 0 Days 21 If less than one day hr. min.

9. Birthplace (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Auto Salesman
11. Industry or business:
FATHER
12. Name: Newton W.Frick
13. Birthplace (City, town, or county) Va. (State or foreign country)
MOTHER
14. Maiden name: Rebecca J. Candler
15. Birthplace (City, town, or county) Va. (State or foreign country)
16. (a) Informant: Mr. W.T.McCoy
(b) Address: 5006 Wabash
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Smithville, Missouri
18. (a) Signature of funeral director Mrs. C.L.Forster
(b) Address Kansas City, Missouri
19. (a) 4-5-45 (Date received local registrar) (b) L. Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 4 year 1945 hour 4 minute 10 A.M.
21. I hereby certify that I attended the deceased from January 15, 1945 to April 4, 1945 that I last saw him alive on April 4, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Empyema	
Due to: Lung abscess	
Due to: 110a	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy: See above

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

23. Signature Clark W Seely M.D. (M.D. or other)
Address Med. Dir. Gen'l Hosp. Date signed 4-4-45

(Licensed Embalmer's Statement on Reverse Side)

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 Joe B Yoder

Licensed Embalmer No. 4173

P. O. Address 918 Brooklyn

K. C. 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.

V. S. No. 2B
0M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 12157

Registration District No. 149 Primary Registration District No. 1002. Registrar's No. 1525

SUPPLEMENTARY

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: Gen. Hosp. #1
(If not in hospital or institution, write street number or location)

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

In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

(c) City or town .....
(If outside city or town limits, write "RURAL")

(d) Street No. .....
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME William Frick

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex .....

5. Color or race .....

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

6. (b) Name of husband or wife .....

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

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

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

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

10. Usual occupation .....

11. Industry or business .....

MOTHER FATHER

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 .....

(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)

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

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

(b) Address .....

19. (a) 4-5-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April ..... day 4 ..... year 1945 ..... hour ..... minute ..... M.

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

	Duration
Immediate cause of death: Empyema (non T.B.)	
Due to: lung abscesses (non T.B.)	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 110a	

Major findings:
Of operations .....
Of autopsy see above

PHYSICIAN

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)

(b) 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 Clark W. Seely (M. D. ~~or other~~)

Address: Gen. Hosp. #1 Date signed 4-4-45

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 23 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 45-12157

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1525

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(a) County: Jackson

(b) City or town: Kansas City
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(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 mos. 19 days (Specify whether years, months or days)

In this community 20 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. 5006 Wabash
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME: William Frick

3. (b) If veteran, name war: No

3. (c) Social Security No. 492-18-6437

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Divorced

6. (b) Name of husband or wife: Mary Frick

6. (c) Age of husband or wife if alive: -- years

7. Birth date of deceased: 3 (Month) 13 (Day) ~~1900~~ 1890 (Year)

8. AGE: Years ~~45~~ 55 | Months 0 | Days 21 | If less than one day ___ hr. ___ min.

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

10. Usual occupation: Auto Salesman

11. Industry or business:

FATHER
12. Name: Newton W. Frick
13. Birthplace: (City, town, or county) Va. (State or foreign country)

MOTHER
14. Maiden name: Rebecca J. Candler
15. Birthplace: (City, town, or county) Va. (State or foreign country)

16. (a) Informant: Mr. ~~W. F. McCoy~~ W.F. McCoy

(b) Address: 5006 Wabash

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-1945 (Month) (Day) (Year)

(c) Place: burial or cremation: Smithville, Missouri

18. (a) Signature of funeral director: Mrs. C.L. Forster

(b) Address: Kansas City, Missouri

19. (a) 4-5-45 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 4 year 1945 hour 4 minute 10 A.M.

21. I hereby certify that I attended the deceased from January 15, 1945 to April 4, 1945 that I last saw him alive on April 4, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Empyema — Duration

Due to: Lung abscess

Due to:

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

Major findings:
Of operations:

Of autopsy: See above

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

110a

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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: Clark W. Seely M.D. (M.D. or other)

Address: Med. Dir. Gen'l Hosp. Date signed 4-4-45

Verified by Family Record- William Frick born March 13, 1890
Items # 7, 8 & 16a corrected by an affidavit of a niece 8/14/78