

S. No. 2
M-5-43
7-5-17-39
I X36671

FEB JUL 13 1945

Registration District No. 77

Primary Registration District No. 3016

Registrar's No. 136

1. PLACE OF DEATH:

(a) County COTE

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

(c) Name of hospital or institution: St. Marys Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME FRANK Fick

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

4. Sex Male **5. Color or race** White

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

6. (b) Name of husband or wife Josephine Boehm **6. (c) Age of husband or wife if alive** 67 years

Birth date of deceased: 3 - 23 - 1865
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>80</u>	<u>3</u>	<u>1</u>	hr. _____ min. _____

9. Birthplace Rich Fountain - Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER, FATHER

12. Name John Fick

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

14. Maiden name Mary Kiedler

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

16. (a) Informant Mr. Herman Fick

(b) Address Rich Fountain

17. (a) Burial **(b) Date thereof** 6-27-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rich Fountain

18. (a) Signature of funeral director Clyde Marton

(b) Address Dinn, Mo.

19. (a) 6-26-45 **(b) Therna Richter**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cass

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

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

(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 24
year 1945 hour 12 minute 20 P.M.

21. I hereby certify that I attended the deceased from June 18, 1945, to June 24, 1945
that I last saw him alive on June 24, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis
Cardiovascular disease
Senility

Due to _____

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

Duration

PHYSICIAN

Major findings: 94W

Of operations _____

Of autopsy _____

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? _____

23. Signature J. A. Osman **(M. D. or other)** _____

Address Jefferson City **Date signed** 6-26-45

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

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 7-12-45

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 Victor Briesche

Licensed Embalmer No. 3701

P. O. Address Jefferson City, 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.