

## FILED JAN 8 1945 STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1408

## 1. PLACE OF DEATH:

(a) County Buchanan  
 (b) City or town St. Joseph  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
 Keck Nursing Home 1501 Francis 4  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 years  
 (Specify whether  
 In this community 4 years  
 years, months or days)

3. (a) PRINT FULL NAME Margaret Froelich

3. (b) If veteran, name war none  
 3. (c) Social Security No. none

4. Sex female / 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 September 11 1938  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
 87 3 15 hr. min.

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

10. Usual occupation at home

11. Industry or business

MOTHER FATHER { 12. Name Casper Froelich  
 13. Birthplace unknown Germany 4  
 (City, town, or county) (State or foreign country)

14. Maiden name Fredrick Brochner  
 15. Birthplace unknown Germany 4  
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Charles E. Zeorlin  
 (b) Address St. Joseph, Mo.

17. (a) cremation (b) Date thereof 12/29/45  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cem. K.C., Mo.

18. (a) Signature of funeral director Heaton, Bickel & Bowman

(b) Address 319 South 10th

19. (a) Jan 2-1946 (b) [Signature] (Registrar's signature)

Date received local registrar

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan //  
 (c) City or town St. Joseph /  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 3312 Seneca 7  
 (If rural, give location)  
 (e) Citizen of foreign country? no 0 (Yes or No)  
 If yes, name country

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 26th  
 year 1945 hour 10 minute 30 P. M.

21. I hereby certify that I attended the deceased from 10-25-  
 1945 to 10-26-1945

that I last saw h. or alive on 10-25-1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death  
 Lobar pneumonia Duration 3da

Due to Cerebral accident

Due to Gen. Arterio sclerosis

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
 Of operations

Of autopsy

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 M. E. Grimes (M. D. certifier)  
 Address Kirkpatrick Bldg. St. Joseph, Mo. Date signed 12-27-45

Dr. M. E. Krimeas  
Kirk Bldg.

**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... *Frank A. Brown*

Licensed Embalmer No. *1710*

P. O. Address *St Joseph*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**