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ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAY 29 1947

2278

Registration District No. 199

Primary Registration District No. 1002

Registrar's No.

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:
General Hospital No. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 hrs.
 In this community 50 YEARS
 years, months or days (Specify whether)

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. 2416 EAST 65TH STREET
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Bernard Fricke
 3. (b) If veteran, name war WORLD WAR I
 3. (c) Social Security No. NONE

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May day 23
 year 1947 hour 10 minute 40 A.M.
 21. I hereby certify that I attended the deceased from May 23, 1947, to 5-23, 1947
 that I last saw him alive on 5-23, 1947
 and that death occurred on the date and hour stated above.

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 2 1891
 (Month) (Day) (Year)

Immediate cause of death acute myocardial infarction
 Duration _____

8. AGE: Years 55 Months 7 Days 21 If less than one day _____ hr. _____ min.

Due to _____
 Due to _____

9. Birthplace KANSAS CITY MISSOURI
 (City, town, or county) (State or foreign country)
 10. Usual occupation RETIRED

Other conditions (Include pregnancy within 3 months of death) 94

11. Industry or business _____
 12. Name BERNARD FRICKE
 13. Birthplace WASHINGTON MISSOURI
 (City, town, or county) (State or foreign country)
 14. Maiden name ANNIE UNKNOWN
 15. Birthplace UNKNOWN
 (City, town, or county) (State or foreign country)

Major findings:
 Of operations _____
 Of autopsy See above
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant MRS. SAM BLOOM
 (b) Address 4238 EAST 60TH TERRACE
 17. (a) CREMATION (b) Date thereof MAY 24 1947
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation D.W. NEWCOMER'S SONS.

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? _____

18. (a) Signature of funeral director D.W. Newcomer's Sons
 (b) Address 1401 BRUSH CREEK BLVD.
 19. (a) 5-24-47 (b) Geraldine Holmes
 (Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
 (c) Means of injury _____
 23. Signature W. W. East (M. D. or other) MD
 Address Med. Dir. Gen'l Hosp Date signed 5-23-47

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

OCT 2 1960
2261
6-28-60
11/15

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... *Edward M. Storey*
Licensed Embalmer No. *4452*
P. O. Address... *K.C. 44th*

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.