

FILED AUG 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6678

318

1003

Registrar's No.

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY					
b. CITY OR TOWN St. Louis.		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN St. Louis		17 4			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Lukes Hospital				d. STREET ADDRESS (If rural, give location) 3929a Vest Avenue 0					
3. NAME OF DECEASED (Type or Print) a. (First) Susan b. (Middle) c. (Last) Frick			4. DATE OF DEATH (Month) (Day) (Year) July 30 1949						
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April-29-1900		9. AGE (In years last birthday) 49	10. MONTHS 3	11. DAYS 2		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Washington, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A			
13a. FATHER'S NAME Henry Holkemeyer		13b. MOTHER'S MAIDEN NAME Elizabeth Sieve		14. NAME OF HUSBAND OR WIFE Joseph Frick					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Joseph Frick ADDRESS					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio sclerosis General. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Nephritis Chronic DUE TO (c) Uremia II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 3 year 6 mo 1 mo	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		17			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR H601					
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 5 P. m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) W. M. D. 4				23b. ADDRESS 508 N Grand		23c. DATE SIGNED 8-1-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8/2/49	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri				
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE AUG 1 1949 J. B. Foster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Stroot-Carroll, 4600 Natural Bridge Ave.							

(Licensed Embalmers' Statement on Reverse Side)

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

No. 300
48

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.....

.....
working under my personal supervision.

Student
Student Embalmer

Student Embalmer No.

Signed *[Handwritten Signature]*
Licensed Embalmer No. *366*
P. O. Address *[Handwritten Address]*

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.