

FILED MAR 7 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6162**  
Registrar's No. **1610**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH  
a. COUNTY \_\_\_\_\_  
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
a. STATE **Mo.** b. COUNTY \_\_\_\_\_

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **St. Louis** c. LENGTH OF STAY (in this place) **8 hours**  
c. CITY OR TOWN **St. Louis** d. Is Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION: **St. Lukes Hospital** e. STREET ADDRESS (If rural, give location) **4340 College Ave.**

3. NAME OF DECEASED a. (First) **Arthur** b. (Middle) **J.** c. (Last) **Frohoff** 4. DATE OF DEATH (Month) (Day) (Year) **Feb. 18 1955**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Widowed** 8. DATE OF BIRTH **Aug. 13 1900** 9. AGE (in years last birthday) **54** IF UNDER 1 YEAR: Months \_\_\_\_\_ Days \_\_\_\_\_ IF UNDER 1 HR.: Hours \_\_\_\_\_ Min. \_\_\_\_\_

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Supervisor** 10b. KIND OF BUSINESS OR INDUSTRY \_\_\_\_\_ 11. BIRTHPLACE (City and State or Foreign Country) **St., Louis Mo.** 12. CITIZEN OF WHAT COUNTRY? **U.S.**

13a. FATHER'S NAME **John J. Frohoff** 13b. MOTHER'S MAIDEN NAME **Josephine Walters** 14. NAME OF HUSBAND OR WIFE **Henrietta Frohoff**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **No** 16. SOCIAL SECURITY NO. **488-16-9559** 17. INFORMANT'S SIGNATURE OR NAME ADDRESS **Donald Frohoff 4340 College Ave.**

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  
MEDICAL CERTIFICATION  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) **SUBARACHNOID HEMORRHAGE** INTERVAL BETWEEN ONSET AND DEATH **12 HRS.**  
\*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.  
ANTECEDENT CAUSES DUE TO (b) **MALIGNANT HYPERTENSION** **1 YR.**  
DUE TO (c) \_\_\_\_\_  
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION \_\_\_\_\_ 19b. MAJOR FINDINGS OF OPERATION \_\_\_\_\_ 20. AUTOPSY? YES  NO

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) \_\_\_\_\_

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) \_\_\_\_\_ 21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR? **330x**

22. I hereby certify that I attended the deceased from **JULY 1<sup>st</sup>**, 19**54**, to **FEBRUARY 18<sup>th</sup>**, 19**55**, that I last saw the deceased alive on **FEBRUARY 18<sup>th</sup>**, 19**55**, and that death occurred at **11:00 a. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **William A. Tabor** 23b. ADDRESS **5535 DELMAR** 23c. DATE SIGNED **2/20/55**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24b. DATE **Feb. 21** 24c. NAME OF CEMETERY OR CREMATORY **Calvary Cemetery** 24d. LOCATION (City, town, or county) (State) **St. Louis Mo.**

DATE REC'D BY LOCAL REG. **FEB 21 1955** REGISTRAR'S SIGNATURE **Carl Smith, M.D.** 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **Buchholz Mortuary 5967 W. Florissant**

(Licensed Embalmer's Statement on Reverse Side)

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

**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 ..... Student Embalmer No. .... working under my personal supervision. .

Student.....  
Signature of Student Embalmer

Signed *W. Fred J. Bralho*.....  
Licensed Embalmer No. *755*

P. O. Address *St. Joe*.....

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.**