

No. 300
10-48

FILED APR 21 1955

STANDARD CERTIFICATE OF DEATH

State File No. 14299

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 812

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Missouri b. COUNTY 224	
b. CITY (If outside corporate limits, write RURAL and give township) Koch, Missouri		c. LENGTH OF STAY in this place 1736d.	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION Robert Koch Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		e. STREET ADDRESS (If rural, give location) 3720 Wisconsin	

3. NAME OF DECEASED (Type or Print) a. (First) Fritz b. (Middle) (Flickiger) c. (Last) Fluckiger		4. DATE OF DEATH (Month) (Day) (Year) April 7, 1955	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widower	8. DATE OF BIRTH 12-11-1870
9. AGE (In years last birthday) 84		10. USUAL OCCUPATION (Give kind of work done during most of his life, even if retired) Nil	11. BIRTHPLACE (City and State or Foreign Country) Switzerland
12. CITIZEN OF WHAT COUNTRY U.S.A.			

13a. FATHER'S NAME Fritz Fluckiger	13b. MOTHER'S MAIDEN NAME Mary Scheidecker	14. NAME OF HUSBAND OR WIFE Bertha Petrig
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. None	17. INFORMANT'S SIGNATURE OR NAME (Address) Robert Koch Hosp, Koch, Mo

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis, general		INTERVAL BETWEEN ONSET AND DEATH 10 yrs ? 5-6 yrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pulmonary tuberculosis, arrested.		
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 002x	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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **June 6, 1950** to **April 7, 1955** that I last saw the deceased alive on **April 7, 1955**, and that death occurred at **11:50 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Bernard Friedman, M.D.	23b. ADDRESS Robert Koch Hosp, Koch, Mo	23c. DATE SIGNED 4.8.55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/11/55	24c. NAME OF CEMETERY OR CREMATORY Mt Hope Cemetery	24d. LOCATION (City, town, or county) (State) St Louis Co Mo.
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DATE REC'D BY LOCAL REG. 4-8-55	REGISTRAR'S SIGNATURE Herbert R. Donke M.D.	25. FUNERAL DIRECTOR'S SIGNATURE J L Ziegenhein & Sons	ADDRESS 7027 Gravois
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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.....
A. P. K. edwell

Licensed Embalmer No. *387*

P. O. Address *7027*

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.