

FILED SEP 22 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **31881**BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **2070**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Koch</b>		c. LENGTH OF STAY (In this place) <b>8/17/54-9/2/55</b>		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Robert Koch Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>3553 So Spring</b> <b>2109</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>WALTER</b> b. (Middle) <b>WILLIAM</b> c. (Last) <b>FRALEY</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>9 2 1955</b>				
5. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>11-21-10</b>		9. AGE (In years last birthday) <b>44</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NIL</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>O-ravelle, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13a. FATHER'S NAME <b>Charles Fraley</b>		13b. MOTHER'S MAIDEN NAME <b>Daze Zimmerman</b>		14. NAME OF HUSBAND OR WIFE <b>Emma</b>			
15. WAS DECEASED EVER IN U. S. ARMY FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give date of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>345-09-9213</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Emma Fraley 3553 So Spring</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <b>MEDICAL CERTIFICATION</b> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary tuberculosis, far advanced 4 yrs.</b> ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH _____			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? <b>002x</b> 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? _____			
22. I hereby certify that I attended the deceased from <b>8/17</b> , 19 <b>55</b> , to <b>9/2</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>9/2/55</b> , 19 <b>55</b> , and that death occurred at <b>1:30 P.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>David M. Hansen, M.D.</b>				23b. ADDRESS <b>Koch Hospital</b>		23c. DATE SIGNED <b>9/2/55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>9/6/55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>N Picker Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St Louis Mo</b>		
DATE REC'D BY LOCAL REG. <b>9/5/55</b>		REGISTRAR'S SIGNATURE <b>Herbert R. Donke M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J L Ziegenhein &amp; Sons 7027 Gravois</b>			

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

SEP 29 1935

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 *E. P. Kidwell*

Licensed Embalmer No. 387

P. O. Address 7027 9th

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.