

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

18867

XC-1992 445

SL 13267 FILED MAY 27 1957

STATE FILE NUMBER

1003

4457

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4457

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>915 N. GRAND, ST. LOUIS, MO.</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VET.ADM. HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>1208a ALLEN</b>	
Length of stay in lb <b>33 days</b>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BERNARD</b> Middle Last <b>FRITZ</b>			4. DATE OF DEATH <b>MAY 8, 1957</b> Month Day Year
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6/5/92</b>
9. AGE (In years last birthday) <b>64</b>	IF UNDER 1 YEAR Months Days Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR</b>	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>OSCAR FRITZ</b>		14. MOTHER'S MAIDEN NAME <b>PAULINE (UNKNOWN)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW-1</b>		16. SOCIAL SECURITY NO. <b>487-18-8475</b>	
17. INFORMANT <b>VA HOSP. RECORDS, ST. LOUIS, MO.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SPINAL CORD COMPRESSION</b>			INTERVAL BETWEEN ONSET AND DEATH <b>UNK</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>METASTATIC CARCINOMA OF SPINE</b>			<b>UNK</b>
DUE TO (c) <b>CARCINOMA OF UNDETERMINED PRIMARY SITE</b>			<b>UNK</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>METASTATIC CARCINOMA OF LIVER</b>			19. WAS AUTOPSY PERFORMED? <b>2</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <b>NONE</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>- - - 199.8</b>	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>4/5/57</b> to <b>5/8/57</b> and last saw <b>xx</b> him alive on <b>5/8/57</b> Death occurred <b>5:45 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (In free or title) <b>Westphaelinger</b>		22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>	22c. DATE SIGNED <b>5/8/57</b>
23a. BURIAL, CREMATION, REMOVAL		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY
<b>M. F. WESTPHELINGER, M. D. NATIONAL CEM.</b>		<b>JEFFERSON BRKS, MO.</b>	
24. FUNERAL DIRECTOR <b>MOYDELL FUNERAL HOME-1926 ALLEN</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 10 '57</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>

2001

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2001-10-10

**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 *Reinhold K. Lehmann*

Licensed Embalmer No. *33*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.