

Health,
Welfare
Public
Service

XC-17 479 320
SI-12909

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-026957
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6196
FILED JUL 18 1958

300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS, MISSOURI		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN MAPLEWOOD 4344
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 35 VAH, 915 N. GRAND AVE.		Length of stay in 1b 16 DAYS	d. STREET ADDRESS (If outside, give location) 27 2519A BELLEVUE AVE. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last RUSSELL E. FROELICH	4. DATE OF DEATH Month Day Year 6/16/58
---	---

5. SEX MALE 0	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/17/90	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
------------------	---------------------------	---	-----------------------------	---------------------------------------	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHOTOGRAPHER - UNEMPLOYED UNKNOWN	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) MASSILON, OHIO /	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	-----------------------------------	--	--

13a. FATHER'S NAME GUS FROELICH	13b. MOTHER'S MAIDEN NAME MINNIE UNKNOWN	14. NAME OF HUSBAND OR WIFE ROSE FROELICH
------------------------------------	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES! W.W.I.	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Address VAH, 915 NO. GRAND AVE., ST. LOUIS, MO.
---	------------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE UPPER GASTROINTESTINAL HEMORRHAGE GASTRIC ULCER & DUADENAL ULCER Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) - - - 5400 - DUE TO (c) - - - - -	INTERVAL BETWEEN ONSET AND DEATH 6 DAYS - -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ADVANCED GENERALIZED ARTERIOSCLEROSIS - CEREBRAL VASCULAR HEMORRHAGE	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <input type="checkbox"/> NONE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---	---	--	---

21. attended the deceased from <u>VA</u> <u>5/31/58</u> to <u>6/16/58</u> and last saw <u>see</u> him <u>live</u> on <u>6/16/58</u> Death occurred at <u>8:50 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <u>V.P. Johnson M.D.</u>	22b. ADDRESS VAH, ST. LOUIS, MISSOURI	22c. DATE SIGNED 6/16/58
--	--	-----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. <u>6-18-58</u>	23c. NAME OF CEMETERY OR CREMATORY OAK HILL CEMETERY	23d. LOCATION (City, town, or county) (State) ST LOUIS CO., MO.
---	---------------------	---	--

24. FUNERAL DIRECTOR ADDRESS JAY B. SMITH, Maplewood, Mo.	25. DATE RECD. BY LOCAL REG. JUN 18 '58	26. REGISTRAR'S SIGNATURE <u>Carl Smith</u> mjb.
--	--	--

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Secretary, coroner, etc., must use only standard nomenclature in Part 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *H. Burgess*

Licensed Embalmer No. *4029*

P. O. Address *Hopewood*

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.