

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006656

STATE FILE NUMBER

FILED FEB 18 1959

Registration District No. 277 Primary Registration District No. 5952 Registrar's No. 12

300
-57

1. PLACE OF DEATH a. COUNTY <u>Pike</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>pike</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Curryville-SPENCER Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Curryville</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RFD # 2</u>		Length of stay in 1b <u>15 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>RFD # 2</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Frieden</u> Last <u>Frieden</u>			4. DATE OF DEATH Month <u>FEB.</u> Day <u>9,</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1, 1881</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>25</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Blue Mounds Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13a. FATHER'S NAME <u>Joseph Gruber</u>		13b. MOTHER'S MAIDEN NAME <u>Johanna Witzko</u>		14. NAME OF HUSBAND OR WIFE <u>John Frieden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mary Francis Frieden Muskogee, Okla</u> 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) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Coronary Arteriosclerosis</u>		<u>8 yrs.</u>	
		DUE TO (c) <u>Hypertension, Arteriosclerosis</u>		<u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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. I attended the deceased from <u>April-1953</u> to <u>2-9-59</u> and last saw her alive on <u>2-9-59</u> . Death occurred at <u>9 o'clock</u> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>J.R. Donaherty M.D.</u>			22b. ADDRESS <u>Vandalia, Mo.</u>		22c. DATE SIGNED <u>2-11-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2-11-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Clement</u>		23d. LOCATION (City, town, or county) (State) <u>St. Clement Missouri</u>
24. FUNERAL DIRECTOR <u>J. Q. Mudd Bowling Green Mo.</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>2-13-59</u>	26. REGISTRAR'S SIGNATURE <u>Bill Robinson</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *James A. Mull*

Licensed Embalmer No. *A152*
P. O. Address *Bowling Green*

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.