

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022891

STATE FILE NUMBER 2-3760  
Registration No. 3760

FILED JUL 1 1959 Registration District No. Primary Registration District No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3943 Cleveland		Length of stay in 1b		d. STREET ADDRESS 3943 Cleveland (If outside, give location)	
3. NAME OF DECEASED (Type or print) First Middle Last E Otto Frick		4. DATE OF DEATH Month Day Year June 16 1959			
5. SEX Male	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 Oct 17 1880	9. AGE (In years last birthday) 78	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General work		10b. KIND OF BUSINESS OR INDUSTRY Flour Mills		11. BIRTHPLACE (City and state or country) Bunker Hill Kansas	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME David B. Frick		13b. MOTHER'S MAIDEN NAME Martha Eastman	
14. NAME OF HUSBAND OR WIFE Mabel Starnes		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.	
17. INFORMANT Mabel Frick		Address 3943 Cleveland			
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>Acute Coronary Occlusion</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>420.1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Amputation of leg above knee</u>					INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
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 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. I attended the deceased from <u>May 58</u> to <u>Sept 58</u> and last saw her alive on <u>Oct 58</u> Death occurred at <u>6-16-59 2:00 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>M. Kimmelman M.D.</u>			22b. ADDRESS <u>1005 My Run</u>		22c. DATE SIGNED <u>6-17-59</u>
23b. DATE <u>June 18, 59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Salina</u>		23d. LOCATION (City, town, or county) (State) <u>Salina Kansas</u>	
24. FUNERAL DIRECTOR <u>E.J. Schnur</u>		ADDRESS <u>3125 Lafayette</u>		25. DATE RECD. BY LOCAL REG. <u>JUN 17 '59</u>	
26. REGISTRAR'S SIGNATURE <u>M.B. Earl Smith, M.D.</u>					

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Thomas R. Jewick*

Licensed Embalmer No. *3793*

P. O. Address *3125 Lafayette*

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.