

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022892
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's **2 5610**

FILED JUN 24 1959

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	a. STATE Missouri b. COUNTY Jefferson
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Baptist Hosp.		Length of stay in lb 1 Day	d. STREET ADDRESS (If outside, give location) R R #2
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First Edwin	Middle G.	Last Frick	4. DATE OF DEATH	Month June	Day 9th	Year 1959
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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 Dec. 18th 1894	9. AGE (In years at birthday)	IF UNDER 1 YEAR Months 64	IF UNDER 24 HRS. Days _____ Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic	10b. KIND OF BUSINESS OR INDUSTRY Auto	11. BIRTHPLACE (City and state or country) Indiana	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME William Frick	13b. MOTHER'S MAIDEN NAME Laura Simon	14. NAME OF HUSBAND OR WIFE Winifred Frick
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give year or dates of service) No	16. SOCIAL SECURITY NO. 494-05-2528H	17. INFORMANT Winifred Frick	Address Above
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA of LARYNX CACHEXIA TERMINAL ASPIRATION PNEUMONIA 161X DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	INTERVAL BETWEEN ONSET AND DEATH 2 yrs
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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.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year a.m. _____ p.m. _____

20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from **FEBRUARY, 1959** to **JUNE 9, 59** and last saw him **live on June 8 '59**
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Waverly M. Frick MD	22b. ADDRESS St Louis 8 Mo	22c. DATE SIGNED 6-9-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6-11-59	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Gardens	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
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24. FUNERAL DIRECTOR JAY B. SMITH, Maplewood, Mo.	25. DATE RECD. BY LOCAL REG. JUN 12 '59	26. REGISTRAR'S SIGNATURE Waverly M. Frick
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All diseases in Part I must be causally related.

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 *J. P. Burgess*

Licensed Embalmer No. *4029*
P. O. Address *Maplewood*

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.