

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027616

FILED VS JUL 21 1959 17

Registration District No. 590 Primary Registration District No. 1984 Registrar's No.

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Shrewsbury</b>		Length of stay in 1b <b>9 1/2 Yrs.</b>		c. CITY OR TOWN <b>Shrewsbury</b>		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>7513 Suffolk Ave.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>7513 Suffolk Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>G.</b> Last <b>FRITZ.</b>				4. DATE OF DEATH Month <b>July</b> Day <b>1</b> Year <b>1959</b>						
5. SEX <b>M</b>	6. COLOR OR RACE <b>B</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>2-17-1880</b>	9. AGE (last birthday) <b>79</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grocer (Retired)</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own account</b>		11. BIRTHPLACE (City and state or country) <b>Berger, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>			
13a. FATHER'S NAME <b>John Fritz</b>			13b. MOTHER'S MAIDEN NAME <b>Josephine Born</b>			14. NAME OF HUSBAND OR WIFE <b>Jane Gallian Fritz</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Jane Fritz,</b>			Address <b>above</b>			
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>Anterior-cleavage Heart Disease</b> DUE TO (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <b>8 years</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
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 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	
21. I attended the deceased from <b>1957</b> to <b>July 1, 1959</b> and last saw him <sup>then</sup> alive on <b>June 25, 1959</b> Death occurred at <b>1:20 p.m.</b> of the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <b>Walter A. Dill MD</b>				22b. ADDRESS <b>7346a Manchester Ave. Maplewood 17, Mo.</b>		22c. DATE SIGNED <b>7-2-59</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7-4-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon Cemetery</b>			23d. LOCATION (City, town, or county) <b>St. Louis Co., Mo.</b>					
24. FUNERAL DIRECTOR <b>JAY B. SMITH, Maplewood 17, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>7-4-59</b>		26. REGISTRAR'S SIGNATURE <b>John C. Murphy, MD</b>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.