

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-038317

FILED VS NOV 16 1959

Registration District No. 317 Primary Registration District No. 542 Registrar's No. 2879

S. 300
1-57

1. PLACE OF DEATH a. COUNTY St. Louis		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 Ferguson		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Ferguson <u>4109</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 535 Averill Avenue		Length of stay in lb. 3 years	d. STREET ADDRESS (If outside, give location) 535 Averill Avenue
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First ADOLPH Middle FRICKE Last			4. DATE OF DEATH Month October Day 28 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 12/20/81	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Operator	10b. KIND OF BUSINESS OR INDUSTRY St. Louis Public Service	11. BIRTHPLACE (City and state or country) Hermann Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME August Fricke	13b. MOTHER'S MAIDEN NAME Adelide Cross	14. NAME OF HUSBAND OR WIFE Christine Fricke
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) no	16. SOCIAL SECURITY NO. 493-10-9317 A	17. INFORMANT Mrs. Fay Courtois	Address 535 Averill Avenue
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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) coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH Immediate
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) atherosclerotic coronary artery disease	
	DUE TO (c) adrenocortical insufficiency	1 year?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201H		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.)
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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
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21. I attended the deceased from 3-21-58 to 10-28-59 and last saw her alive on 9-29-59 Death occurred at 1:00 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) Clifton K. Dudalet MD	22b. ADDRESS 7500 Senaslene	22c. DATE SIGNED 10-29-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct 30, 1959	23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
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24. FUNERAL DIRECTOR Shepard Funeral Home, 1167 Hamilton Ave	25. DATE RECD. BY LOCAL REG. 10-29-59	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 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 *Stanley H. Dixon*

Licensed Embalmer No. *4193*

P. O. Address *St. Louis*

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.