

DURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 3 8 2 8

FILED VS. DEC 21 1959-116

STATE FILE NUMBER

Registration District No. 222 Primary Registration District No. 3020 Registrar's No. 271

1. PLACE OF DEATH a. COUNTY <u>Franklin</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington</u> Length of stay in lb <u>***</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>**</u> b. COUNTY <u>**</u> c. CITY OR TOWN <u>**</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>**</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>PATRICIA</u> Middle <u>SUE</u> Last <u>FROLKER.</u>				4. DATE OF DEATH Month <u>December</u> Day <u>15</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 checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12-15-1959</u>		9. AGE (last birthday) IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u> IF UNDER 24 HR Hours <u>6</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>**</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>**</u>		11. BIRTHPLACE (City and state or country) <u>Washington, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>** USA.</u>		
13a. FATHER'S NAME <u>Billie Harold Frolker</u>				13b. MOTHER'S MAIDEN NAME <u>Florence Curtman Frolker</u>			14. NAME OF HUSBAND OR WIFE <u>**</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Billie Frolker</u> Address <u>Owensville, Mo.</u>				
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>Prematurity (a premature 5 mo)</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Leptospirosis</u> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH _____	
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 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 <u>12-15-59</u> to <u>12-15-59</u> and last saw her alive on <u>12-15-59</u> 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) <u>Charles Schmidt MD</u>					22b. ADDRESS <u>General Mo.</u>			22c. DATE SIGNED <u>12-15-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specification) <u>burial</u>		23b. DATE <u>12-16-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Owensville, Mo.</u>			
24. FUNERAL DIRECTOR <u>Robert Service</u> ADDRESS <u>Owensville</u>					25. DATE RECD. BY LOCAL REG. <u>12/19/59</u>		26. REGISTRAR'S SIGNATURE <u>J.P. Henderson</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Robert Service
Margaret N. Winter
 OWENSVILLE
 (Licensed Embalmer's Statement on Reverse Side)

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 NO EMBALMING
Myron H. H. [Signature]

Licensed Embalmer No. 383

P. O. Address OWENSVILLE

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.