

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS DEC 23 1959**

'59 0 4 5 4 4 2  
 STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's **211537**

RECEIVED  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>St. Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>101 days</b>	c. CITY OR TOWN <b>Glasgow Village</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>De Paul Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>10404 Durness Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Gary</b> Middle <b>A</b> Last <b>Froehly</b>			4. DATE OF DEATH Month <b>December</b> Day <b>11</b> Year <b>1959</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-25-1959</b>	9. AGE (last birthday) IF UNDER 1 YEAR Months <b>7</b> Days <b>16</b> Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			13a. FATHER'S NAME <b>Gene R. Froehly</b>		
13b. MOTHER'S MAIDEN NAME <b>June Becher</b>			14. NAME OF HUSBAND OR WIFE <b>-----</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 Address <b>Gene R. Froehly, 10404 Durness Drive</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>Brain abscess</b>					INTERVAL BETWEEN ONSET AND DEATH <b>9-1-59</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. ) DUE TO (b) <b>none</b>					<b>342x</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) <b>none</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 <b>9-1-59</b> to <b>12-11-59</b> and last saw <sup>her</sup> him alive on <b>12-11-59</b> Death occurred at <b>10:45 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Walter H. Spoenemann M.D.</b>			22b. ADDRESS <b>1515 St. Louis</b>		22c. DATE SIGNED <b>12-12-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec. 14, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Friedens Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Missouri</b>	
24. FUNERAL DIRECTOR <b>Math Hermann &amp; Son, Inc., 2161 E. Fair Ave</b>			25. DATE RECD. BY LOCAL REG. <b>DEC 14 1959</b>		26. REGISTRAR'S SIGNATURE <b>Neal Smith M.D.</b> <b>MSB</b>

**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 *John W. Ray*

Licensed Embalmer No. 3737

P. O. Address St. Louis Mo

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.