

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-023170**

**FILED VS JUN 17 1960**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3024

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>50 yrs.</b>	c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. HOSEPH HOSP.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>6721 VIRGINIA</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>VAL</b> Middle <b>ENTINE</b> Last <b>FRICK</b>	4. DATE OF DEATH Month <b>JUNE</b> Day <b>3</b> Year <b>1960</b>
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</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>8 15 80</b>	9. AGE (last birthday) <b>79 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CUSTODIAN BOARD OF EDUCATION</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>DUBOIS CO. INDIANA</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>JACOB FRICK</b>	13b. MOTHER'S MAIDEN NAME <b>ELISE RISCH</b>	14. NAME OF HUSBAND OR WIFE <b>ISABEL FRICK</b>
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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>-</b>	17. INFORMANT Address <b>ISABEL FRICK 5721 VIRGINIA</b>
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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) <b>Bronchopneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	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) <b>Parkeisonism, arteriosclerosis</b>	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
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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 <b>10</b> 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
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21. I attended the deceased from <b>May 1, 1960</b> to <b>June 3, 1960</b> and last saw him alive on <b>June 3, 1960</b> Death occurred at <b>3:00 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree & title) <b>Albert J. Decker MD</b>	22b. ADDRESS <b>Kansas City, Mo.</b>	22c. DATE SIGNED <b>6-4-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>JUNE 6, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FOREST HILL CEM</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MO.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>D. W. NEWCOMER'S SONS K. C. MO.</b>	25. DATE RECD. BY LOCAL REG. <b>June 6, 1960</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>
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(Licensed Emballer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF MEDICAL CERTIFICATION  
**Albert J. Decker**

**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 *B. D. Helman*

Licensed Embalmer No. 4401

P. O. Address K.C.M.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.