

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

| | | | | | | | | |
|--|--|---|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 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 ST. LOUIS, MISSOURI | | Length of stay in 1b | | c. CITY OR TOWN Overland | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 2413 Gilrose Avenue | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last FRANK WILLIAM FRESE | | | 4. DATE OF DEATH Month Day Year JANUARY 27 1961 | | | | | |
| 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 9-11-1894 | 9. AGE (last birthday) 66 yrs | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman | | 10b. KIND OF BUSINESS OR INDUSTRY McMullen Printing | | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | |
| 13a. FATHER'S NAME Gerhardt Frese | | | 13b. MOTHER'S MAIDEN NAME Sophia Koettenstedt | | | 14. NAME OF HUSBAND OR WIFE Rose M. Frese | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Rose M. Frese, 2413 Gilrose Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <i>O.K. Jagt in June</i> <i>Sept 1960</i> Conditions, if any, which gave rise to above cause (b), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 30 MINUTES 8 YEARS | |
| IMMEDIATE CAUSE (a) SUSPECTED MYOCARDIAL INFARCTION | | | | | DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE | | | |
| DUE TO (c) 420.0 | | | | | | | | |
| 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 Month, Day, Year a.m. p.m. | | | | | | | | |
| 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 JUNE 18, 1960 to JANUARY 27, 1961 last saw her him alive on JULY 16, 1960 Death occurred at 8:20 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (D. name or title) <i>Bernard M. Parker M. D.</i> | | | | 22b. ADDRESS BARNES HOSPITAL | | 22c. DATE SIGNED 1/27/61 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Jan. 30, 1961 | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Louis Missouri | | | | |
| 24. FUNERAL DIRECTOR ADDRESS Kriegshauser, 9450 Olive St. Rd. | | | 25. DATE RECD. BY LOCAL REG. JAN 28 1961 | | 26. REGISTRAR'S SIGNATURE <i>Earl Smith M.D.</i> | | | |

EMERALD, IOWA

THE IOWA BOARD OF HEALTH

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 Richard W. Stovesand

Licensed Embalmer No. 4007

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.