

MISSOURI DEPARTMENT OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

=62-003768

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. **18** Primary Registration District No. **1003** Registrar's No. **324**

STATE FILE NUMBER

|  |   |   |   |  |   |  |
|--|---|---|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |  |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>  |   | Length of stay in 1b  | c. CITY OR TOWN <b>St. Louis</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Enroute City Hospital</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>446 N. Sarah St.</b>  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>William</b> Middle <b>A.</b> Last <b>Frye</b>   |   |   | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>6</b> Year <b>1962</b>  |  |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/12/1882</b>  | 9. AGE (last birthday)<br><b>79</b>  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>retired</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Mo. Pac. R.R.</b>   | 11. BIRTHPLACE (City and state or country)<br><b>Topeka, Kansas</b>   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.</b>   |   |  |
| 13a. FATHER'S NAME<br><b>Daniel Frye</b>   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Eldina Maze</b>   |   | 14. NAME OF HUSBAND OR WIFE<br><b>Unavailable</b>  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   | 17. INFORMANT<br>Address<br><b>Mrs. H.R. Constable, Topeka, Kansas</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease;</b><br>DUE TO (b) <b>Generalized Arterio Sclerosis.</b><br>DUE TO (c) <b>4200</b> |   |   |   |  | 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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 _____ to _____ and last saw him alive on _____<br>Death occurred at <b>390 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.   |   |   |   |  |   |  |
| 22a. SIGNATURE<br><i>Joseph D. Truman</i><br>(Degree or title)   |   |   | 22b. ADDRESS<br><b>1300 Clark</b>   |  | 22c. DATE SIGNED<br><b>1-8-62</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  | 23b. DATE<br><b>1-9-62</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Hope Cemetery</b>  | 23d. LOCATION (City, town, or county)<br><b>Topeka, Kansas</b>  |  | (State)   |  |
| 24. FUNERAL DIRECTOR<br><b>Albert H. Hoppe, Inc., 4700 Washington Blvd.</b>  |   | ADDRESS   | 25. DATE RECD. BY LOCAL REG.<br><b>JAN 8 1962</b>   | 26. REGISTRAR'S SIGNATURE<br><i>Carl Smith, M.D.</i>   |   |  |

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

9

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

*Robert M. Murray*

Licensed Embalmer No. 3749

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.