DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28853

Registration District No. 784-425 Primary Registration District No. ~~200~~ 5580 Registrar's No. 177

1. PLACE OF DEATH:

(a) County ~~Jefferson~~ ~~St. Louis~~

(b) City or town RURAL — MERAMEC (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph's Hill Infirmary (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 months (Specify whether years, months or days)

In this community 4 months

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Valley Park (If outside city or town limits, write "RURAL")

(d) Street No. Route 1 (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Sloan Fry

3. (b) If veteran, name war ____

3. (c) Social Security No. NONE

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife ____

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased Oct (Month) 16 (Day) 1876 (Year)

8. AGE: Years 63 Months 8 Days 28 If less than one day ____ hr. ____ min.

9. Birthplace Clinton Pa (City, town, or county) Pensylvania (State or foreign country)

10. Usual occupation Plate Glass Maker, (Retired)

11. Industry or business ____

FATHER 12. Name David T. Fry

FATHER 13. Birthplace Clinton (City, town, or county) Pa (State or foreign country)

MOTHER 14. Maiden name Emma Burkey

MOTHER 15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Brother Roch, C.S.F.

(b) Address St. Joseph's Hill Infirmary

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 8-5-40 (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis Crematory

18. (a) Signature of funeral director St. Louis Co. Funeral Home

(b) Address Clayton Mo. Pu. Fr. Brown

19. (a) AUG 5 - 1940 (Date received local registrar) (b) A.R. Meyer M.D. D.P.H. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 4 year 1940 hour Five minute 10 A.M.

21. I hereby certify that I attended the deceased from Feb 4, 1940, to June 1, 1940; that I last saw him alive on June 1, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Valvular Heart Disease	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ____

(b) Date of occurrence ____

(c) Where did injury occur? ____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature Jesse S. Sargent (M. D. or other)

Address Eureka, Mo. Date signed 6-4-40

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.