. No. 2
1—2-43
5-17-39
I X35697

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 11 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18075

Registration District No. 317 Primary Registration District No. 3069 Registrar's No. 1282

1. PLACE OF DEATH:

(a) County St Louis Co.

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

(c) Name of hospital or institution: St Mary Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Hours (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis

(c) City or town ######St Agnes Home. (If outside city or town limits, write "RURAL")

(d) Street No. 10341 Manchester (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME JAMES (NICK) FRICKE

3. (b) If veteran, name war

3. (c) Social Security No. 488-16-7218

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife CLARA FRICKE

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

7. Birth date of deceased 20. Aug. 1868 (Month) (Day) (Year)

8. AGE: Years 76 Months 9 Days 11 If less than one day hr. min.

9. Birthplace Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Door man

FATHER
12. Name ? Fricke
13. Birthplace Unknown (City, town, or county) (State or foreign country)

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

16. (a) Informant August Menetre

(b) Address 3424 Juniata St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5/45 (Month) (Day) (Year)

(c) Place: burial or cremation Old S.S. PETER & PAUL

18. (a) Signature of funeral director Thos Lutes & Son

(b) Address 2906 Gravois Ave.

19. (a) JUN 4 1945 (Date received local registrar) (b) E. E. McCauran (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 1 year 1945 hour 3 05 P.M. minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of the skull

Due to Manslaughter (Auto accident)

Due to 16

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

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

(b) Date of occurrence June 1st, 1945,

(c) Where did injury occur? Kirkwood, Mo. (City or town) (County) (State)

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

While at work? (e) Means of injury

23. Signature Arnold J. Willmann Coroner (M. D. or other)

Address Clayton, Mo. Date signed 6-4-45

(Licensed Embalmer's Statement on Reverse Side)

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 David Van Fossan

Licensed Embalmer No. 4242

P. O. Address 2906 Grassia

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 this body is not embalmed, fact should be so stated above.

. No. 21
M—3-45
I X43880

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18075

Registration District No. 317 Primary Registration District No. 3069 Registrar's No. 1282

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME James Fricke
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug (Month) 20 (Day) 1868 (Year)
8. AGE: Years 76 Months 4 Days 12 If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Day 1 year 1945 hour 13:00 minute P. M.
21. I hereby certify that I attended the deceased from ..., 19..., to ..., 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.
Immediate cause of death Fracture of the skull
Due to
Due to Manslaughter. This man was a pedestrian struck by auto which left scene of accident.
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy No

Duration

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) Homicide
(b) Date of occurrence June 1st, 1945
(c) Where did injury occur? Kirkwood, Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Highway (Specify type of place)
While at work? (e) Means of injury Automobile
23. Signature Arnold J. Willmann (M. D. or other) Coroner.
Address Clayton, Mo. Date signed 6-4-45

SUPPLEMENTARY