

THE DIVISION OF HEALTH OF MISSOURI
FILED AUG 2 1949 STANDARD CERTIFICATE OF DEATH

State File No. **25637**

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 6076		Registrar's No. 1616	
1. PLACE OF DEATH a. COUNTY St Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) Affton		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) Affton			
d. FULL NAME OF HOSPITAL OR INSTITUTION 5019 Frankfort				d. STREET ADDRESS (If rural, give location) 5019 Frankfort			
3. NAME OF DECEASED (Type or Print) a. (First) James		b. (Middle) H		c. (Last) Fritsche		4. DATE OF DEATH (Month) (Day) (Year) July 7, 1949	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Aug 24, 1931		9. AGE (In years last birthday) 17	IF UNDER 1 YEAR Months	IF UNDER 11 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St Louis, Mo.		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Herb Fritsche			13b. MOTHER'S MAIDEN NAME Ruth Kelsey		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ruth Fritsche 5019 Frankfort			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial pneumonia				2 days	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Spastic paralysis		Unknown	
				DUE TO (c) General debility		2 years	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				351X	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 10, 1946 , to July 7, 1949 , that I last saw the deceased alive on July 7, 1949 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Melissa R. Wilucki MD (D)				23b. ADDRESS 8301 E. Gravois		23c. DATE SIGNED 7-8-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 7/9/49	24c. NAME OF CEMETERY OR CREMATORY Lakewood Park Cemetery		24d. LOCATION (City, town, or county) (State) St Louis County, Mo.		
DATE REC'D BY LOCAL REG. 7-8-49		REGISTRAR'S SIGNATURE Herb R. Dube MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ziegenhein & Sons 7027 Gravois			

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

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
Student Embalmer

Signed _____

W. G. Peterson

Licensed Embalmer No. _____

3767

P. O. Address _____

7027 Gravis

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.