

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 2803  
0476

FILED JAN 26 1952

BIRTH NO. 4123-52 REG. DIST. NO. PRIMARY REG. DIST. NO. Registrar's No.

1. PLACE OF DEATH a. COUNTY		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 township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Firmin Desloge Hospital		d. STREET ADDRESS (If rural, give location) 1722 So. 14th 4	
3. NAME OF DECEASED (Type or Print) a. (First) Frederick b. (Middle) Joseph c. (Last) Frick		4. DATE OF DEATH (Month) (Day) (Year) 1-12-52	
5. SEX Male	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) -	8. DATE OF BIRTH 1-12-52
9. AGE (In years last birthday) 7		IF UNDER 1 YEAR Months Days	
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? 0	

13a. FATHER'S NAME Joseph Henry Frick	13b. MOTHER'S MAIDEN NAME Mary Ruth Gray	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. -	17. INFORMANT'S SIGNATURE OR NAME Mary Ruth Frick	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 7 hours
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory Failure		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Prematurity DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 776X
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22. I hereby certify that I attended the deceased from ~~1-12~~ 1-12, 1952, to 1-12, 1952, that I last saw the deceased alive on 1-12, 1952, and that death occurred at 10:15pm., from the causes and on the date stated above.

23a. SIGNATURE A. R. Sharp (Degree or title) M.D.	23b. ADDRESS St. Mary's Hospital, St. Louis	23c. DATE SIGNED 1-13-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 1-16-52	24c. NAME OF CEMETERY OR CREMATORY CALHOUN	24d. LOCATION (City, town, or county) (State) St. Louis MO
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DATE REC'D BY LOCAL REG. JAN 16 1952	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. H. O'NEAL & KELLY 4386 LINCOLN
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 *Not Embalmed* .....

Licensed Embalmer No. ....

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