

## STANDARD CERTIFICATE OF DEATH

2785

State File No. ....

BIRTH NO. FILED FEB 4 1954 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 0873

1. PLACE OF DEATH a. COUNTY St. Louis Mo				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) St. Louis Mo		c. LENGTH OF STAY (in this place) 4 1/2 yrs (10 mos 4 days)		c. CITY OR TOWN St. Louis Mo		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Chronic Hospital				e. STREET ADDRESS 1837a Menard					
3. NAME OF DECEASED (Type or Print) a. (First) Frank			b. (Middle)		c. (Last) Frueh		4. DATE OF DEATH (Month) (Day) (Year) I 25 54		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Jan. 21, 1883		9. AGE (In years last birthday) 71		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (City and State or Foreign Country) Illinois			12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME Bernard			13b. MOTHER'S MAIDEN NAME Alexia Krusen			14. NAME OF HUSBAND OR WIFE Della			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Della Frueh 1123 Dillon Drive					
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Arteriosclerotic Heart Disease</i>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <i>Generalized Arteriosclerosis</i>  DUE TO (b)  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH <i>years</i> <i>years</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <i>420.0</i>					
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?					
22. I hereby certify that I attended the deceased from <i>3/22/49</i> , 19 <i>49</i> , to <i>1/25</i> , 19 <i>54</i> , that I last saw the deceased alive on <i>1/25</i> , 19 <i>54</i> , and that death occurred at <i>12:PM</i> m., from the causes and on the date stated above.									
23a. SIGNATURE <i>George Esker, M.D.</i> (Degree or title)				23b. ADDRESS 5600 Arsenal St				23c. DATE SIGNED <i>1/25/54</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		24b. DATE <i>1-28-54</i>		24c. NAME OF CEMETERY OR CREMATORY <i>St. Matthews Cemetery</i>		24d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>			
DATE REC'D BY LOCAL REG. <i>JAN 27 1954</i>		REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>McLaughlin Funeral Home 2301 Lafayette</i>				

(Licensed Embalmer's Statement on Reverse Side)

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.....  
Signature of Student Embalmer

Signed *H. G. Ferris*.....

Licensed Embalmer No. *33*.....  
P. O. Address *2301 Tappan*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.