

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24962

FILED JUL 20 1956

State File No.

318

1003

6253

BIRTH NO. _____		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 <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Missouri</u>		c. LENGTH OF STAY (in this place) <u>D.O.A.</u>		c. CITY OR TOWN <u>St. Louis</u>		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 <u>City Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>5537 Wren Ave.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Fred</u> b. (Middle) <u>G.</u> c. (Last) <u>Froeschner</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 1, 1956</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widower</u>		8. DATE OF BIRTH <u>Jan. 28, 1879</u>	
9. AGE (In years last birthday) <u>77</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 4 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Stove Moulder</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Frederick Froeschner</u>			13b. MOTHER'S MAIDEN NAME <u>Caroline Meyer</u>			14. NAME OF HUSBAND OR WIFE <u>deceased</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>328-03-0590</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Frieda Calvin 5537 Wren Ave.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, atherosclerosis, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>F.A. Tbc (Far Advanced T.B.C.)</u> ANTECEDENT CAUSES <u>Bronchial Asthma</u> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Bronchial Asthma</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>008X</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>002x</u>				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) _____			
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 <u>5-1-55</u> , 19 <u>55</u> , to <u>6-30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/29</u> , 19 <u>56</u> , and that death occurred at <u>6:50a</u> m., from the causes and on the date stated above. <u>7-3-56</u>							
23a. SIGNATURE <u>Chas. S. Rosen M.D.</u>				23b. ADDRESS <u>599 No. Grand</u>		23c. DATE SIGNED <u>7-9-56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>7-5-56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Zions Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Missouri.</u>	
DATE REC'D BY LOCAL REG. <u>JUL 3 1956</u>		REGISTRAR'S SIGNATURE <u>Carly Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Math Hermann & Son, Inc. 2161 E. Fair Ave.</u>			

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.....
Chew W. Day

Licensed Embalmer No. *5757*

P. O. Address *J. Lavin*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.