

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035888

STATE FILE NUMBER

FILED OCT 30 1958

Registration District No. 87 Primary Registration District No. 5324 Registrar's No. 9

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>CRAWFORD</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>1</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BOONE</u>		c. CITY OR TOWN <u>ST LOUIS</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>GROTE MACK LAKE 2 DAYS</u>		d. STREET ADDRESS (If outside, give location) <u>3713 WINNEBAGO</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM JOSEPH FROST</u>		4. DATE OF DEATH <u>OCT 26 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 1 1893</u>
9. AGE (In years last birthday) <u>64</u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BREWING</u>
11. BIRTHPLACE (City and state or country) <u>ST. LOUIS MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH MRAZEK FROST</u>		14. MOTHER'S MAIDEN NAME <u>MARY CATHERINE KASLAKIA</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>489-05-1789</u>	
17. INFORMANT <u>V. FLORENCE FROST</u>		Address <u>3713^E WINNEBAGO</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>coronary artery disease</u>			<u>5 yrs.</u>
DUE TO (c) <u>atherosclerosis</u>			<u>many years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour <u>6:00</u> a. m. p. m.	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
21. I attended the deceased from <u>never</u> to <u>never</u> and last saw <u>her</u> alive on <u>never</u> . Death occurred at <u>6:00</u> a. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Ronald Van Arsdell, M.D.</u>		22b. ADDRESS <u>Bourbon, Mo.</u>	22c. DATE SIGNED <u>27 OCT 58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>OCT 27 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>DAK GROVE CEM</u>	23d. LOCATION (City, town, or county) (State) <u>ST LOUIS COUNTY MO</u>
24. FUNERAL DIRECTOR <u>Thomas Kutis</u> ADDRESS <u>2906 Gravois</u>		25. DATE RECD. BY LOCAL REG. <u>10/27/58</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

NON FEBRUARY 1959

FEB 10 1959

NOV 3 1958

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 *Homer C Dill*

Licensed Embalmer No. *43*

P. O. Address *2906 Sm*

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