

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010915

STATE FILE NUMBER

2 2383

FILED MAR 20 1959 Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

300

1-57

49

195

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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

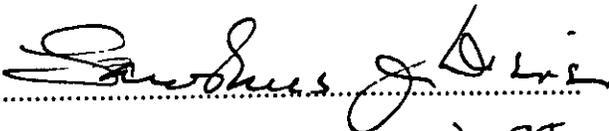
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED (Type or print) Joseph (Orthodox) A. C. Frey HOSPITAL OR Folks Home INSTITUTION Length of stay in lb 76 yrs.			d. STREET ADDRESS 1438 E. Grand		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED First Middle Last JOSEPH FREY			4. DATE OF DEATH Month Day Year March 6, 1959		
5. SEX male 0	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1882	9. AGE (In years (If birthday) ¹⁻³¹ 76) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME David Frey		13b. MOTHER'S MAIDEN NAME Sophie (unk)		14. NAME OF HUSBAND OR WIFE -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Karol Korngold 721 Olive		
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>Arteriosclerosis, Generalized.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <u>450 D</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>(a) Chronic Brain Syndrome (b) Debilitation</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Yrs.</u>
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 Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from <u>1953</u> to <u>3/6/59</u> and last saw ^{her} him alive on <u>3/5/59</u> . Death occurred at <u>10:00 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Kay Freybaum M.D.</u> (Degree or title)			22b. ADDRESS <u>4452 Maryland.</u>		22c. DATE SIGNED <u>3/5/59.</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>3/8/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Sinai</u>		23d. LOCATION (City, town, or county) (State) <u>Afton, Mo.</u>
24. FUNERAL DIRECTOR <u>Berger Memorial 4715 McPherson</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>MAR 7 '59</u>		26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>

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 
Licensed Embalmer No. 3988

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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