

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-012080

FILED VS APR 4 1960 277

Registration District No. Primary Registration District No. 4411 Registrar's No. 14

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Pike		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Pike	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bowling Green		Length of stay in 1b 2 Yrs	c. CITY OR TOWN Bowling Green Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION B B Springs Rest Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) N Main Cross Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First HARRY Middle LEE Last FRY			4. DATE OF DEATH Month March Day 23 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Feb 2 1881	9. AGE (last birthday) 79	IF UNDER 1 YEAR Months 1 Days 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) ST. LOUIS - COUNTY - MO.		12. CITIZEN OF WHAT COUNTRY US
13a. FATHER'S NAME SIMON - FRY		13b. MOTHER'S MAIDEN NAME LAURA BELL LONG		14. NAME OF HUSBAND OR WIFE None	
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. None		17. INFORMANT 4410 Matthews Irene Smith St. Louis, Mo.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS.			UNKNOWN.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) CARCINOMA METASTASIS OF TISSUE SLOUGH INTO RIGHT INTERNAL CAROTID.		CONDITION EXISTED
	DUE TO (c) CERVICAL METASTASIS OF LINGUAL CARCINOMA.		7-24-1959 ON FIRST EXAM.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) NONE			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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 9:20 a.m. p.m.	Month, Day, Year 7-24-1959		
20d. INJURY OCCURRED WHILE AT WORK <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 St. Louis, Mo	COUNTY STATE

21. I attended the deceased from **7-24-1959** to **3-23-1960** and last saw ^{her}him alive on **3-8-1960**.
Death occurred at **9:20** **A.m** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Ralph H. Hayden M.D.		22b. ADDRESS 519 WEST MAIN - Bowling Green - Mo		22c. DATE SIGNED 3/23/1960
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-23-60	23c. NAME OF CEMETERY OR CREMATORY Memorial Park	23d. LOCATION (City, town, or county) (State) St. Louis, Mo	
24. FUNERAL DIRECTOR ADDRESS A. Kron North Grand Ave. St. Louis, Mo.		25. DATE RECD. BY LOCAL REG. 3-30-60	26. REGISTRAR'S SIGNATURE Gill Robinson	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 5 1889

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James O. Madd

Licensed Embalmer No. 4152

P. O. Address Burlington

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.