

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

11416-62-044226

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. _____

FILED NOV 30 1962

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF
1						
2 <u>202</u>						
3						
4 <u>0</u>						
5 <u>1</u>						
6						
7 <u>0</u>						
8 <u>2</u>						
9						
10						
11						
12 <u>58-0</u>						
13						
<u>58</u>						

1. PLACE OF DEATH a. COUNTY - - -		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY - - -	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Missouri</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b <u>12 days</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Deaconess Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>6058 Guilford Place</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>A/K/a First Henry Vourdon Fricke</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>27,</u> Year <u>1962</u>	
Last <u>Fricke</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>2-13-1897</u>
		9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR Months _____ Days _____
			IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>
			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Henry Fricke</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Bosch</u>	
		14. NAME OF HUSBAND OR WIFE <u>Edna Fricke</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>yes</u>	
		17. INFORMANT <u>Mrs. Edna Fricke</u>	
		Address <u>6058 Guilford Pl.</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>acute Myocardial Infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Artery Thrombosis</u>			<u>12 days</u>
DUE TO (c) <u>Coronary Arteriosclerosis</u>			<u>6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u>			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.) <u>4201</u>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
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	COUNTY STATE
21. I attended the deceased from <u>3-20-59</u> to <u>11-27-62</u> and last saw him alive on <u>11-27-62</u> Death occurred at <u>3:30 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) <u>James T. Murphy</u>		22b. ADDRESS <u>634 N. Grand Blvd.</u>	22c. DATE SIGNED <u>11-27-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-29-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New St. Marcus</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>
24. FUNERAL DIRECTOR <u>HOFFMEISTER COLONIAL MORTUARY</u>		25. DATE RECD. BY LOCAL REG. <u>NOV 27 1962</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
ADDRESS <u>SAM</u>			

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. James P. Murphy
Missouri Theatre Building

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 *Lin C. Branson*

Licensed Embalmer No. 4764

P. O. Address St Louis Mo

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.