

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-008620

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2705

STATE FILE NUMBER

FILED MAR 14 1963

V6000
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis, Mo.</u>		Length of stay in 1b <u>2 wks.</u>	c. CITY OR TOWN <u>UNIVERSITY CITY</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BERNARD NURSING HOME</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>904 DALKEITH DR</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>L</u> Last <u>FRECH</u>			4. DATE OF DEATH Month <u>3</u> Day <u>7</u> Year <u>63</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</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>10-22-1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>72</u> IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HR: Hours <u> </u> Min. <u> </u>
11. BIRTHPLACE (City and state or country) <u>DE SOTO MO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>WILLIAM J MAUTHE</u>		13b. MOTHER'S MAIDEN NAME <u>MARY SCHAEFER</u>	
14. NAME OF HUSBAND OR WIFE <u>HARRY E FRECH</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>4</u>		17. INFORMANT Name <u>HARRY E FRECH</u> Address <u>904 DALKEITH</u>	
18. CAUSE OF DEATH (Enter only one cause per death) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) <u> </u> DUE TO (c) <u>332x</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <u> </u> Month, Day, Year <u> </u>		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 <u> </u> COUNTY <u> </u> STATE <u> </u>	
21. I attended the deceased from <u>1956</u> to <u>1963</u> and last saw her <u>live on</u> <u>3-7-63</u> Death occurred at <u>8</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Paul O. Hagemann MD</u> (Degree or title)		22b. ADDRESS <u>3720 Washington</u>	22c. DATE SIGNED <u>3-8-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>3-9-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VALHALLA</u>	23d. LOCATION (City, town, or county) (State) <u>ST LOUIS MO</u>
24. FUNERAL DIRECTOR <u>KRIEGSHAUSER</u> ADDRESS <u>9450 OLIVE ST RD</u>		25. DATE RECD. BY LOCAL REG. <u>MAR 8 1963</u>	26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>

USE BLACK INK OR TYPEWRITER RIBBON

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DR PAUL HAGEMANN
3720 WASHINGTON
JE-1-6646

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 _____ Signed William D. White
Signature of Student Embalmer

Licensed Embalmer No. 4291
P. O. Address 4228 So Kingsleyway

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.