

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041846

FILED VS NOV 16 1959

2 8887

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

MEMORIALIZED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission): a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 1 Day	c. CITY OR TOWN Aftton
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 9440 McKenzie Road
3. NAME OF DECEASED (Type or print) First BABY DAVID Middle _____ Last FRITZSCHE		4. DATE OF DEATH Month September Day 25 Year 1959	
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 9/24/59
9. AGE (last birthday)		IF UNDER 1 YEAR Months _____ Days 1 Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME Alfred G. Fritzsche	
13b. MOTHER'S MAIDEN NAME Arlene Rose		14. NAME OF HUSBAND OR-WIFE _____	
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 Address Mr. Alfred G. Fritzsche, 9440 McKenzie Rd.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) anoxia @ = atelectasis of both lungs Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) due to agenesis of lung tissue DUE TO (c) 7590			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Prematurity (36 wks)		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 checked="" type="checkbox"/> NO <input 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.) none	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	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 9/24/59 to 9/25/59 and last saw him alive on 9/25/59 Death occurred at 5:10 P. m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Wm J. H. Lawrence M.D.	
22b. ADDRESS 3804 Wilkington Ave		22c. DATE SIGNED 9/26/59	
23a. BURIAL, CREMATION, REMOVAL Removal	23b. DATE Sept. 26, 1959	23c. NAME OF CEMETERY OR CREMATORY Immanuel Lutheran Cemetery	23d. LOCATION (City, town, or county) (State) Mt. Olive, Illinois
24. FUNERAL DIRECTOR Beiderwieden F.H. Inc., 1936 St. Louis	25. DATE RECD. BY LOCAL REG. 9-26-1959	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

3804 Washington

Nov. 1-7224

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 Not Embalmed, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Norman N. Grehler
Funeral Director
Licensed Embalmer No. _____

P. O. Address 3620 Chippewa

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.