

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

42720

1. PLACE OF DEATH

County..... Registration District No. **791**
 Townshp..... Primary Registration District No. **0703**
 City **St. Louis, Mo.** (No. **Lutheran Hospital**)

File No.....
 Registered No. **12507**
 St..... Ward.....

2. FULL NAME

Magdaline E. Froell
 (a) Residence. No. **13530 = McLean** St. **16** Ward.....
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 9 - 1865.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
 64 10 13

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **House Work**
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) **St. Louis, Mo.**
 (STATE OR COUNTRY)

10. NAME OF FATHER **Christ Froell**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Germany**
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Margaret Bernhard**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Germany**
 (STATE OR COUNTRY)

14. INFORMANT **August Froell**
 (Address) **bx 36 Alma**

15. FILED **DEC 24 1929** **May C. Parsberg** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Dec. 22 - 1929.**

17. I HEREBY CERTIFY, That I attended deceased from **Nov 3**, 1929, to **Dec 22**, 1929 that I last saw her alive on **Dec 22**, 1929, and that death occurred, on the date stated above, at **10:50 P.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Colon
 (duration) yrs. **8** mos. ds.

CONTRIBUTORY (SECONDARY) **Metastasis of Liver**
 (duration) yrs. **?** mos. ds.

18. WHERE WAS DISEASE CONTRACTED

NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? **No** DATE OF.....

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS **clinical + laboratory findings**
 (Signed) **C. E. Mueller**, M. D.

1929. (Address) **3537 S. Jefferson**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Our Redeemer**

DATE OF BURIAL **12-26-1929.**

20. UNDERTAKER **Ziegenhein Bros. 2623 Cherokee**

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

294

1

10

