

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

Do not use this space.

3308 ~~3194~~
~~2737~~

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **1003**

File No.....
Registered No. **805**
St..... Ward)

2. FULL NAME

Fred W. Foedtle
(a) Residence. No. **3231 Neeshol St.** **15** 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 Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Katherine Foedtle		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9-14-1875		
7. AGE	YEARS 54	MONTHS 4
	DAY 9	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Painter		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY) **Illinois**

PARENTS	10. NAME OF FATHER Carl Foedtle
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany
	12. MAIDEN NAME OF MOTHER Unkown
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unkown

14. INFORMANT **Katherine Foedtle**
(Address) **3231 Neeshol St**

15. **Jan 25 1930**
FILED **19** **New E. Starck**
REGISTRAR

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Jan 23 1930**

17. **No Physician in Attendance**
HEREBY CERTIFY, That I attended deceased from.....
....., 19....., to....., 19.....

that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

ruptured
granulosa
of the ovary.
(duration)..... yrs..... mos..... ds.
Non Traumatic

CONTRIBUTORY (SECONDARY)
(duration)..... yrs..... mos..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) **John J. Curley** M.D.

1/24, 1930 (Address) **124 Depue St**

*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 **No Crematory** DATE OF BURIAL **1-26 1930.**

20. UNDERTAKER **Ziegenhain Bros. 2623 Heister St.** 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

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