

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

Do not use this space.

28033

File No. _____
Registered No. **7862**
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **1003**
City **St. Louis Mo.** (No. **Mo. Baptist Hosp.**)

2. FULL NAME **Carl F. Fredrickson**

(a) Residence. No. _____ St. **12** Ward. **Detroit Michigan**
(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

MEDICAL CERTIFICATE OF DEATH

3. SEX **M.** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Single**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Aug. 5, 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.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Feb. 3, 1891**

THE CAUSE OF DEATH WAS AS FOLLOWS: **69**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	39	6	2	

**Hypostatic Pneumonia
Shock & Injuries received
when auto overturned
Bunker Hill Ill.**

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Auto Inspector** **2/0**
(b) General nature of industry, business, or establishment in which employed (or employer) **111**
(c) Name of employer **Ford Motor Car Co.**

CONTRIBUTORY (SECONDARY) **Accident**
(duration) _____ yrs. _____ mos. _____ ds.

9. BIRTHPLACE (CITY OR TOWN) **Bunker Hill**
(STATE OR COUNTRY) **Ill.**

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

PARENTS
10. NAME OF FATHER **Charles Fredrickson**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Bunker Hill.**
(STATE OR COUNTRY) **Ill.**
12. MAIDEN NAME OF MOTHER **Margaret Lange**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Hamilton**
(STATE OR COUNTRY) **Ohio**

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? **yes**

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **J. W. Ferner, M.D.**
8/6, 1930 (Address) **Dep. Coroner**

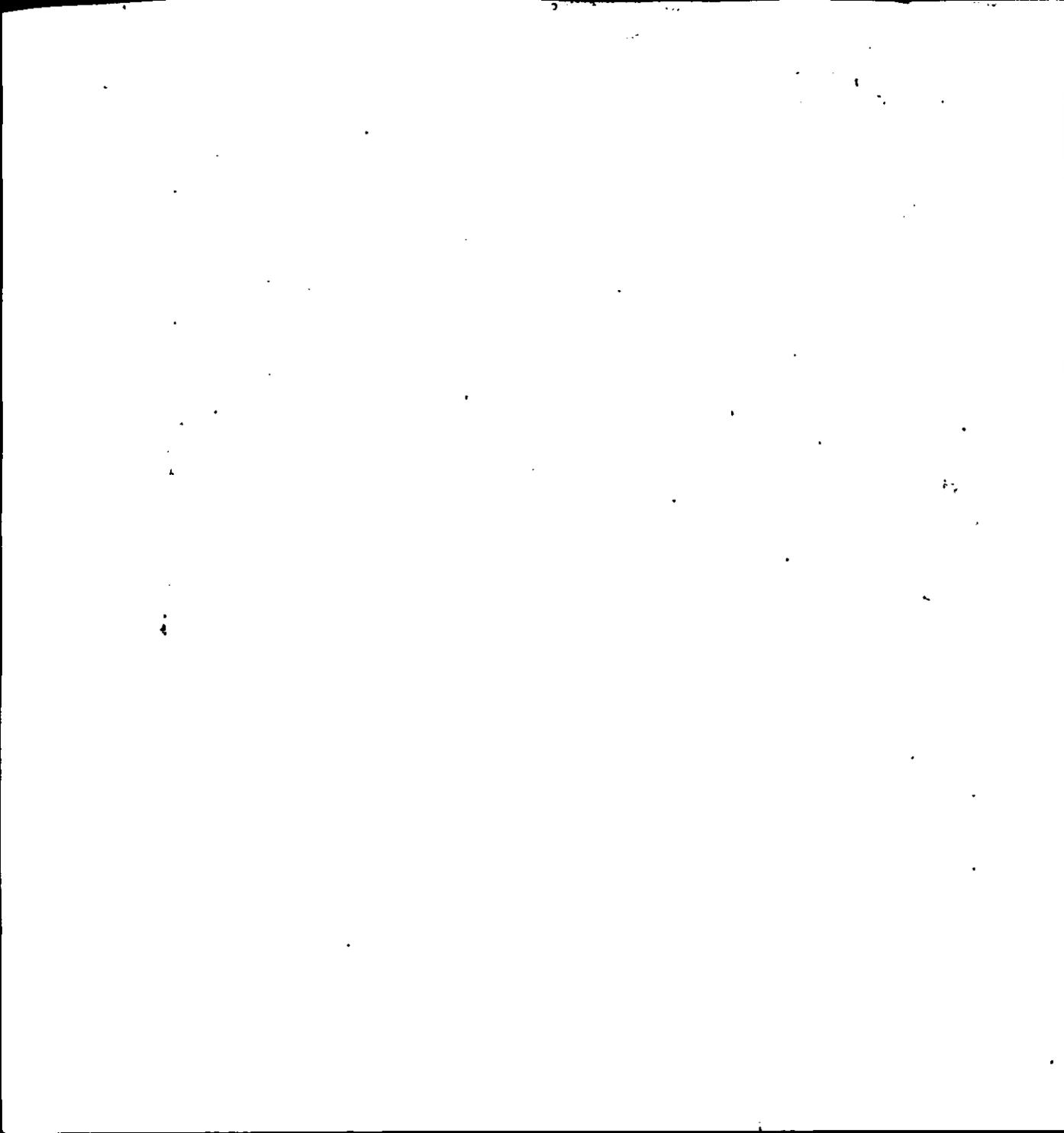
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT **Mrs. R. S. Tiller**
(Address) **4525 Lindell Blvd.**

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Bunker Hill. Ill.** DATE OF BURIAL **8/7/30** 19

15. FILED **Aug -6 1930** **Max C. Starkey** REGISTAR

20. UNDERTAKER **Jacoby Bros.** ADDRESS **Bunker Hill Ill.**



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County St. Louis
Township St. Louis
City St. Louis (No.)

Registration District No. 791
Primary Registration District No. 1003

File No.
Registered No. 7862
St. Ward

2. FULL NAME

Carl F. Fredrickson

(a) Residence, No. St. 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

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 5 1930

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

17. I 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.

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

Suppurative Pneumonia
Shard injuries
Received in auto accident

8. OCCUPATION OF DECEASED

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

Whether Blinded by lights
or hit in head on spring to foot

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

18. WHERE WAS DISEASE CONTRACTED do not know

IF NOT AT PLACE OF DEATH.....

10. NAME OF FATHER

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

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

WAS THERE AN AUTOPSY 1880

12. MAIDEN NAME OF MOTHER

WHAT TEST CONFIRMED DIAGNOSIS.....

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

(Signed)....., M. D.

, 19 (Address)

*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.

14. INFORMANT (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

15. FILED 201-91 Max C. Stankoff REGISTRAR

20. UNDERTAKER ADDRESS

REGISTRARS: ...L NOT RECEIVE A FEE FOR ... STATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
CAUSE 02 54 H in plain terms, so that it may be classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

5-28033