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

Do not use this space.

41293

File No. .....

Registered No. 11966

1. PLACE OF DEATH

County .....

Township .....

City St Louis (No. ..... St. ..... Ward)

Registration District No. 701

Primary Registration District No. 1003

2. FULL NAME Friederika Riedel

(a) Residence. No. 2125 Dakota ave. Ward. 9

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 21st 1836

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
94	1	—	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

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

PARENTS

10. NAME OF FATHER Charles Grünich

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

12. MAIDEN NAME OF MOTHER not known

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

14. INFORMANT Albert Riedel

(Address) 2125 Dakota ave

15. FILED 2 23 1931, 19.. Max C Varner REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 21 1930

17. I HEREBY CERTIFY, That I attended deceased from January, 1927, to Dec 21, 1930, that I last saw her alive on Dec 21, 1930 and that death occurred, on the date stated above, at 11:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Double Lobar Pneumonia

~~Hemiplegia Left side~~

(duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (SECONDARY) Hemiplegia Left side

(duration) 3 yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Lumbar

(Signed) Henry H Dryer, M. D.

, 19 (Address) 3024 Dr Grand

*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 St Peters

DATE OF BURIAL Dec 23 1930

20. UNDERTAKER Edward Koch

ADDRESS 3516 N 14th

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.