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.

NOV 16 1938

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

791

34379
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. 1003

(b) Township ..... Primary Registration District No. ..... Registered No. 9365

(c) City St. Louis (d) Street No. City Hospital No.1 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

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

D.9673

2. PRINT FULL NAME 625 William A. Froeckman

(a) Residence, No. 1405 Pine St. 25
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): divorced

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Aug 14, 1874

7. AGE: 64 YEARS | MONTHS: 2 | DAYS: 12 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.: electrician
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): St. Louis, O

FATHER
13. NAME: Ernest Froeckman
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Germany 6

MOTHER
15. MAIDEN NAME: Minnie Aschendorf
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Germany 6

17. INFORMANT (ADDRESS): Hosp. Info M.Kent

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Valhalla Crematory DATE: Oct. 28, 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Albert H. Hoppe Inc. 4700 Washington Blvd

20. FILED OCT 28 1938 19 J. F. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 10/26/38, 19

22. I HEREBY CERTIFY, That I attended deceased from 10/2/38, 19 10/26/38, 19

I last saw him alive on 10/26/38, 19 Death is said to have occurred on the date stated above, at 5.35 m

The principal cause of death and related causes of importance were as follows:

Duodenal ulcer, bleeding, acute pancreatitis. 117 B

Date of onset

Other contributory causes of importance:

Name of operation: Stomach resection Date of: 10-26-38

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur?
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify: Albert H. Krause
(Signed) , M. D.
(Address) City Hospital No.1

(Licensed Embalmer's Statement on Reverse Side)

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 .....

Registered Apprentice No....., working under my personal supervision.

Signed Albert W. Kappe

Licensed Embalmer No. 1861

P. O. Address 4700 Washington

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.