

DEC 13 1938

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

41802

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
 (b) Township Kaw Primary Registration District No. 1002 Registered No. 4868  
 (c) City Kansas City (d) Street No. St. Joseph Hospital 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 2 1/2 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Florence FREBEL

(a) Residence, No. 923 Cherry St. St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 30, 1895

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hra. or .....min.  
43 3 12

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Clerk.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (year) spent in this occupation 1

12. BIRTHPLACE (CITY OR TOWN) Minneapolis  
 (STATE OR COUNTRY) Minnesota

13. NAME Charles Wolfenden.

14. BIRTHPLACE (CITY OR TOWN) Iowa.  
 (STATE OR COUNTRY)

15. MAIDEN NAME Maria Jones.

16. BIRTHPLACE (CITY OR TOWN) Wisconsin.  
 (STATE OR COUNTRY)

17. INFORMANT Mr. Charles Wolfenden  
 (ADDRESS) Iowa.

18. BURIAL, CREMATION, OR REMOVAL PLACE Sioux Falls DATE 12-13-38  
South Dakota.

19. FUNERAL DIRECTOR (NAME) Melody McGilley.  
 (ADDRESS) K. C. Mo.

20. FILED Dec 13 1938 M. M. Brown  
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-12-1938

22. I HEREBY CERTIFY, That I attended deceased from 12-6- 1938, to 12-12- 1938  
 I last saw her alive on 12-12- 1938. Death is said to have occurred on the date stated above, at 7:30 P. m.  
 The principal cause of death and related causes of importance were as follows:

Lobar pneumonia Date of onset 12-6-38  
108  
 Other contributory causes of importance: Cold

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? no 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? no  
 If so, specify \_\_\_\_\_ (Signed) D. M. Neary M. D.  
 (Address) 525 Argyle Bldg.

Kansas City, Mo.

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.

---

---

**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.....

Licensed Embalmer No.....

P. O. Address.....

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

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