

WRITE CLEARLY, WILL UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

20837
Do not use this space.

5681

1. PLACE OF DEATH

(a) County..... / Registration District No. 791
(b) Township..... / Primary Registration District No. 1008
(c) or City St. Louis (d) Street No. City Hospital No. 1
(If death occurred in Hospital or Institution, write its name instead of street and number)
(f) How long in U. S., if of foreign birth? yrs. mos. ds. yrs. mos. ds.

2. PRINT FULL NAME

Fred Frillman

(a) Residence, No. 3206 North Wharf St. 26 (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 male 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 Unknown

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 27, 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 8 4

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. nil
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) Germany

13. NAME William Frillman

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

15. MAIDEN NAME Louise Craber

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

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

18. BURIAL, CREMATION, OR REMOVAL PLACE City Cemetery DATE 6/30/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) David, Van Horn

20. DIED JUN 28 1939 J. P. Bidlack Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/1/39

22. I HEREBY CERTIFY, That I attended deceased from 4/8/39, 19 to 6/1/39, 19

I last saw him alive on 6/1/39, 19. Death is said to have occurred on the date stated above, at 9.30 a.m.

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

Broncho-pneumonia

Date of onset

Other contributory causes of importance: Rheumatoid arthritis, Rheumatoid Endocarditis

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? 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 Willoum Sapsin, M. D.
(Signed) City Hospital No. 1
(Address)

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

Raymond C. Hehrke
working under my personal supervision.

Levine
Registered Apprentice No. *2985* (City # *99*)

Signed *R. C. Campbell*

Licensed Embalmer No. *6381* (City # *10*)

P. O. Address *St. Louis Mo*

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.