DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23309

Registration District No. 784

Primary Registration District No. 210

Registrar's No. 1055

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Wellston
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 6730 Roberts Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)

In this community ____

2. USUAL RESIDENCE OF DECEASED:

(a) State ____ (b) County ____

(c) City or town ____ (If outside city or town limits, write "RURAL")

(d) Street No. ____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME 1034 Infant Fridley.

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife ____

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased June (Month) 13 (Day) 1939. (Year)

8. AGE: Years Stillborn. Months ____ Days ____ If less than one day ____ hr. ____ min.

9. Birthplace St. Louis County, (City, town, or county) Missouri. (State or foreign country)

10. Usual occupation None

11. Industry or business 0

FATHER
12. Name Norris Fridley.
13. Birthplace Defiance, (City, town, or county) Missouri. (State or foreign country)

MOTHER
14. Maiden name Grace Bishop.
15. Birthplace Milia, (City, town, or county) Arkansas. (State or foreign country)

16. (a) Informant's own signature Mr. Norris Fridley.
(b) Address 6730 Roberts Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13, 1939 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Lebanon Cemetery.

18. (a) Signature of funeral director Geo. L. Pleitsch Inc.
(b) Address 5966-68 Easton Ave.

19. (a) JUN 13 1939 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 12 year 1939 hour — minute — M.

21. I hereby certify that I attended the deceased from Stillborn 6-13- 1939, to 6-13- 1939; that I last saw h— alive on Stillborn 1939; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Stillborn	
Due to —	
Due to —	
Other conditions (Include pregnancy within 3 months of death) Stillborn	

Major findings:
Of operations —
Of autopsy —

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ✓
(b) Date of occurrence ✓
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ✓ (Specify type of place)
While at work? ✓ (e) Means of injury ✓

23. Signature J. D. Thurman (M. D. or other)
Address 6753 Page Date signed 6-13-39

(Licensed Embalmer's Statement on Reverse Side)

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 wit the above constitutes grounds for revocation of license.)

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

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

23309
Do not use this space.

1. PLACE OF DEATH
(a) County St Louis — Registration District No. 784
(b) Township Wellston — Primary Registration District No. 200 — Registered No. 1055
(c) City ..... (d) Street No. ..... 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.

2. PRINT FULL NAME Infant Fridley
(a) Residence, No. ..... St. ☐ .....
(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 F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-13-1939
7. AGE YEARS Stillborn MONTHS DAYS 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.
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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

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

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 6-13 1939 G R Meyer MD Dr PH
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 13, 1939

22. I HEREBY CERTIFY, That I attended deceased from 6-13, 1939 to 6-13, 1939
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at ..... m 39
The principal cause of death and related causes of importance were as follows:

Stillborn

Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....
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 .....
(Signed) J. D. Thurman, M. D.
(Address) 6753 Page

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

STATE BOARD OF HEALTH
VITAL STATISTICS
TE OF DEATH

Do not use this space.

1. PLACE OF DEATH

(a) County

(b) Township

(c) City (d) Ill.

(e) Length [illegible] or town where death occurred

Registered No.

Sl.

[illegible] of street and number)

of foreign birth? yrs. mo. da.

2. PRINT FULL NAME

(a) Residence, No.

(Usual place of abode, if no street address [illegible] county or [illegible] and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)	21. DATE OF DEATH

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

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

7. AGE	YEARS	MONTHS	DAYS	[illegible]

NOTAPUCCO

8. Trade, profession, or particular kind of work done, as lawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month [illegible] year)

12. BIRTHPLACE (CITY OR [illegible] STATE OR COUNTRY)

FATHER

13. NAME

14.