

17 1939
 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.
 WHILE MAINLY USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. 40773
 Registrar's No. 2007

Registration District No. 784 Primary Registration District No. 200

1. PLACE OF DEATH:
 (a) County St. Louis,
 (b) City or town Jennings
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community _____
 years, months or days

8. (a) PRINT FULL NAME Mamie Frohoff, 610
 3. (b) If veteran, name war no 3. (c) Social Security No. None
 4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased July 21st, 1970
 (Month) (Day) (Year)

8. AGE: Years 69 Months 3 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER { 12. Name Jacob Licht,
Germany
 13. Birthplace _____ (City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Mathilda Miller
 15. Birthplace France
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ray Pomathi
 (b) Address 8814 College Ave.,

17. (a) Burial (b) Date thereof Nov. 18th, 1939
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation St. Peters Cem.

18. (a) Signature of funeral director Wm. C. ...
 (b) Address 1417 N. Market Street

19. (a) NOV 17 1939 (b) Ray Pomathi
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County _____
 (c) City or town Jennings, Mo.
 (If outside city or town limits, write "RURAL")
 (d) Street No. 8814 College Ave.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Nov day 15th
 year 1939 hour 7⁵⁵ minute _____ P. M.
 21. I hereby certify that I attended the deceased from Sept 12th, 1939, to Nov 15th, 1939;
 that I last saw her alive on Nov 15th, 1939;
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 1 wks

Due to arterio-sclerosis Chronic myocarditis unknown

Due to _____
 Other conditions _____ (include pregnancy within 3 months of death) 930

Major findings: Of operations none Of autopsy none
 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 _____

23. 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? _____

While at work? _____ (Specify type of place) (a) Means of injury _____
 23. Signature James ... (M. D. or other) no
 Address 6201 Lotus Date signed 11-16-39

Er. Michs

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 *Homer L. Gonder*

Licensed Embalmer No. *9367*

P. O. Address *R. 223 St. Louis*

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.