FILED JUN 14 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19370

Registration District No. 757 Primary Registration District No. 3036 Registrar's No. 80

1. PLACE OF DEATH:

(a) County St Charles

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

(c) Name of hospital or institution: St Joseph's Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Charles

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

(d) Street No. 210 S. Kingshighway (If rural, give location)

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

3. (a) PRINT FULL NAME MRS FRIEDA MALLINCKRODT

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 Married

6. (b) Name of husband or wife Dr. P. L. Mallinckrodt 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased October (Month) 4th (Day) 1893 (Year)

8. AGE: Years 46 Months 7 Days 7 If less than one day ____ hr. ____ min.

9. Birthplace Foley (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name J. H. Wallenbrock
13. Birthplace St Charles (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Wilhelmina Dieckmeyer
15. Birthplace ____ (City, town, or county) Germany (State or foreign country)

16. (a) Informant's own signature Paul Mallinckrodt Jr

(b) Address St Charles Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 14 1940 (Month) (Day) (Year)

(c) Place: burial or cremation St Johns Cemetery

18. (a) Signature of funeral director [illegible]

(b) Address 326 N 6th St - St Charles Mo

19. (a) 5/13/40 (Date received local registrar) (b) Clarence G. Hessler (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11 year 1940 hour 7 minute 05 A. M.

21. I hereby certify that I attended the deceased from Apr 9, 1940 to May 11, 1940 that I last saw her alive on May 10th, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Congestion of Lungs. Due to Pernicious Anaemia

Due to ____

Due to ____

Other conditions None (Include pregnancy within 3 months of death)

Major findings: Of operations ____

Of autopsy ____

Duration 24 hr. 1 yr.

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 A P Erich Schuh (M. D. or other)

Address St Charles Mo Date signed May 13 1940

(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. Arthur C. Bauer

Licensed Embalmer No. 3155

P. O. Address. St. Charles Mo.

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

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