

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 190 17

Primary Registration District No. 2007

Registrar's No. 1295

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:  
6720 Crest Ave.  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 6720 Crest Ave.  
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Geraldine Grace Fredensburg

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Female 5. Color or race W

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

6. (b) Name of husband or wife Jacob Fredensburg 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased July 16th. 1893  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

49	10	15	.....hr. ....min.
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9. Birthplace Centralia, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business.....

12. Name Gerald Smyth

13. Birthplace Ireland  
(City, town, or county) (State or foreign country)

14. Maiden name Ade Donague

15. Birthplace Dont Know  
(City, town, or county) (State or foreign country)

16. (a) Informant Jacob Fredensburg

(b) Address 6720 Crest Ave.

17. (a) Burial (b) Date thereof 6-4-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Provost Und. Co.

(b) Address 3710 N. Grand Blvd.

19. (a) JUN 2 1943 (b) C. V. M. Larsen, M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31st.  
year 1943 hour 2.25 minute P. M.

21. I hereby certify that I attended the deceased from....., 19..... to....., 19.....;  
that I last saw her alive on May 31, 1943,  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumo pneumonia Dyspnea

Due to right hemiplegia 7 1/2 yrs.

Due to arterio sclerosis many  
hypertension nephrosclerosis

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none 131

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?.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature Joseph Majidow (M. D. or other) MD

Address 500 West 1st Date signed June 1, 1943

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

For Marcellus  
520 West 4th St  
Ca. 885;

PC 0133

6-8

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**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 me

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed A. A. Smithers

Licensed Embalmer No. 3916

P. O. Address 3710 N. Grand Bl

**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, fact should be so stated above.**