

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 38478
 Registrar's No. 2576

FILED NOV 17 1945
 Registration District No. _____

Primary Registration District No. 2070

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

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Webster Groves
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
522 Sunnyside 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

3. (a) PRINT FULL NAME Dora B. Fredeking

3. (b) If veteran, name war Nil 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife William Fredeking 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased September 13 1870
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>1</u>	<u>25</u>	_____ hr. _____ min.

9. Birthplace Elkton Illinois /
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name James R. Parks

13. Birthplace Unknown Unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Spicy Kinyon

15. Birthplace Unknown Unknown 0
(City, town, or county) (State or foreign country)

16. (a) Informant R.M. Fredeking
 (b) Address 522 Sunnyside Ave.

17. (a) Removal (b) Date thereof 11-9-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Alton, Illinois

18. (a) Signature of funeral director Albert H. Hoppe
 (b) Address 4700 Washington Blvd.

19. (a) 11-10-45 (b) E. J. M. Farra M.D.
(Date received local registrar) (Registrar's signature) 256

2. USUAL RESIDENCE OF DECEASED:
 (a) State Illinois (b) County Madison 999
 (c) City or town Alton 11
(If outside city or town limits, write "RURAL")
 (d) Street No. 18 E. 5th St. 0
(If rural, give location) 2
 (e) Citizen of foreign country? _____
(Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 8
 year 1945 hour 5 minute 532 M.

21. I hereby certify that I attended the deceased from November 7th, 1945, to Nov. 8, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Intens. arterio-sclerotic heart disease
(genuine) pneumonia

Due to _____

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

Major findings:
 Of operations _____
 Of autopsy _____

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 H. O. Paulsen (M. D. or other) _____
 Address 19 E. Lombard Date signed 11/9/45

Duration	PHYSICIAN
<u>19 mo.</u>	_____
<u>6 mo.</u>	_____

Underline the cause to which death should be charged statistically.

DEC 13 1943

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 John Gonoski
Licensed Embalmer No 3398
P. O. Address.....

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.