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5-17-39
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DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS
FILED FEB 20 1946 STANDARD CERTIFICATE OF DEATH

7447

State File No. 1423
Registrar's No.

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5317 Cabanne 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 Mary Katherine Fredrickson
3. (b) If veteran, name war Nil
3. (c) Social Security No. Unknown

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 August 4 1894
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
51 6 7 hr. min.

9. Birthplace Bunker Hill Illinois
(City, town, or county) (State or foreign country)
10. Usual occupation Housework

11. Industry or business _____
12. Name Charles Fredrickson
13. Birthplace Bunker Hill Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Long
15. Birthplace Unknown Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Dorothy A. Tilles
(b) Address 5317 Cabanne Ave.
17. (a) Removal (b) Date thereof 2-11-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bunker Hill, Ill.

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

19. (a) FEB 11 1946 (b) J. F. Bredenk
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County McCoupin
(c) City or town Bunker Hill
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 11
year 1946 hour 9:20 minute 0 M.
21. I hereby certify that I attended the deceased from Sept 17 1945 to Feb 11 1946
that I last saw her alive on Feb 11 1946
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis
Hypertension
Duration 7 years

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 9/3/46

Major findings: Of operations _____
Of autopsy _____
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 Hervey M. Meyer (M. D. or other) M.D.
Address 508 N. Grand Date signed 2/11/46

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

MOTHER FATHER

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..... *Albert G. Haggie*

Licensed Embalmer No. *2971*

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.