S. No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED MAR 16 1946

State File No. 10627

Registration District No. 217 Primary Registration District No. 3063 Registrar's No. 605

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution From 3-8-46 to 3-11-46 (Specify whether years, months or days)
In this community 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis 96
(c) City or town University City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 1023 Leona 5
(If rural, give location)
(e) Citizen of foreign country? ~~(Yes or No)~~ No
If yes, name country

3. (a) PRINT FULL NAME Theodore Tredup
3. (b) If veteran, name war No
3. (c) Social Security No. 489-18-3419
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife None
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased Sept. 6, 1869 (Month) (Day) (Year)
8. AGE: Years 76 Months 6 Days 5 If less than one day ____ hr. ____ min.
9. Birthplace Germany (City, town, or county) (State or foreign country)
10. Usual occupation Odd Jobs
11. Industry or business —
FATHER 12. Name Charles Tredup
FATHER 13. Birthplace Germany (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Unknown
MOTHER 15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Patient
(b) Address As above
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Mar. 13/46. (Month) (Day) (Year)
(c) Place: burial or cremation Milwaukee, Wisconsin
18. (a) Signature of funeral director Jos. W. Clark
(b) Address 1125 Hodiamont Ave.
19. (a) 3-12-46 (Date received local registrar) (b) F. H. McGavran M.D. (Registrar's signature) 256

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11 year 1946 hour 2 minute 10 P.M.
21. I hereby certify that I attended the deceased from 3-8- 1946 to 3-11- 1946 that I last saw him alive on 3-11- 1946 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pneumonia (Virus)	
Cardiac Decompensation	
Due to Arteriosclerosis	
Heart Disease	Unknown
Due to 930	
Other conditions None (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
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
(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 Joseph D. Judy (M. D. or other)
Address 601 Brentwood Blvd. Date signed 3/11/46

(Licensed Embalmer's Statement on Reverse Side)

MAR 22 1946

APR 1 1946

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 Alfred F. Borbeker

Licensed Embalmer No. 2663

P. O. Address 1125 Hodiamont Ave.,

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.