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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED MAY 9 1947

Registration District No. #70538 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15723

Primary Registration District No. 1003

Registrar's No. 4288

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution:
St. Louis City Hospital, Max Starkloff Memorial
(If not in hospital or institution, write street number or location)

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

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 24 000 17

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

(d) Street No. 3311 Wisconsin
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME FRANK TIEDE

3. (b) If veteran, name war

3. (c) Social Security No. 492-07-5586

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Minnie Tiede

6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased Mar. 2 1900
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
47	1	24	hr. min.

9. Birthplace St. Louis U
(City, town, or county) (State or foreign country)

10. Usual occupation Brewery Worker

11. Industry or business

MOTHER FATHER

12. Name Julius Tiede

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

14. Maiden name Caroline Gentz

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

16. (a) Informant Minnie Tiede

(b) Address 3311 Wisconsin

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 4-28-47
(Month) (Day) (Year)

(c) Place: burial or cremation N. St. Marcus

18. (a) Signature of funeral director Witt Bros & Co.

(b) Address 2929 S. Jefferson Av.

19. (a) APR 27 1947
(Date received local registrar)

(b) J. F. Broderick
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26th
year 1947 hour 12:40 minute A M.

21. I hereby certify that I attended the deceased from 4-21-47, 19..., to 4-26-47, 19...; that I last saw him alive on 4-26-47, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Brain Tumor	1 year
Due to Unqualified.	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause of 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) Nature of injury

23. Signature George O. Smith (M. D. or other)

Address 1515 Lafayette Date signed 4-26-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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

Signed.....Edgar F. Witt.....
Licensed Embalmer No.....2107.....

P. O. Address.....

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, fact should be so stated above.