

No. 2  
12-45  
1-17-39  
EX-47070

**FILED JUL 7 1947**

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

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: **1916 1/2 MACKLIND 1**  
(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 **Sophie FREY**  
3. (b) If veteran, name war **No**  
3. (c) Social Security No. **No**

4. Sex **female** 5. Color or race **white**  
6. (a) Single, widowed, married, divorced **Widowed**  
6. (b) Name of husband or wife **Phillip Frey**  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **Nov 3 1860**  
(Month) (Day) (Year)

8. AGE: Years **86** Months **7** Days **23**  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **HERMAN MO**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name **Joseph Frey Bawer**  
13. Birthplace **GERMANY**  
(City, town, or county) (State or foreign country)  
14. Maiden name **CATHERINE BAUER**  
15. Birthplace **GERMANY**  
(City, town, or county) (State or foreign country)

16. (a) Informant **MRS. BERTHA GIUDICE**  
(b) Address **1916 1/2 MACKLIND**

17. (a) **BURIAL** (b) Date thereof **JUNE 30 1947**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **MEMORIAL PARK**

18. (a) Signature of funeral director **Paul P. Calcutt**  
(b) Address **5142 Daggett Ave.**

19. (a) **JUL 29 1947** (b) **J.F. Baedek**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **ST. LOUIS**  
(c) City or town **St. Louis MO**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **1916 1/2 Macklind 1**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **26**  
year **1947** hour **9:00** minute **P.M.** M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
that I last saw him **or** alive on **6-26-47**  
and that death occurred on the date and hour stated above.

Immediate cause of death **(1) Cerebral Hemorrhage 1 day**

Due to **(2) Arteriosclerosis - 2 yrs**

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? \_\_\_\_\_

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

23. Signature **W. L. ...** (M. D. or other) \_\_\_\_\_

Address **1407 So Grand** Date signed **6-28-47**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

**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.....

*James C. Calcaterra*

Licensed Embalmer No. 2376

P. O. Address 5147 Dagget

**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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. JulyRegistration District No. 318Primary Registration District No. 1003Registrar's No. 1618

## 1. PLACE OF DEATH:

- (a) County.....  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:

(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 Sophie Frey

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....

7. Birth date of deceased
- Nov 3 1902
- 
- (Month) (Day) (Year)

8. AGE: Years 86 Months 7 Days 2 (If less than one day, hr. min.)

9. Birthplace..... (City, town, or county) (State or foreign country) No

## 10. Usual occupation.....

## 11. Industry or business.....

12. Name.....  
 13. Birthplace..... (City, town, or county) (State or foreign country)  
 14. Maiden name.....  
 15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) June-29-1947 (b) J. F. Budock  
 (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State..... (b) County.....  
 (c) City or town..... (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 July Day 26  
 year 1947 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....  
 that I last saw him/her alive on..... 19.....  
 and that death occurred on the date and hour stated above.

Immediate cause of death.....  
 Duration.....

Due to.....

Due to.....

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

Major findings:.....  
 Of operations.....

Of autopsy.....

## 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..... (M. D. or other)

Address..... Date signed.....

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

SUPPLEMENTARY

JUL 27 1947

22233

2241