

No. 300
-10-47
5-17-39
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FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED APR 7 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

10356

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **2889**

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179
9
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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:
1100 E. Gano 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 Life years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 600
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17
(d) Street No. 1100 E. Gano Ave (If rural, give location) 9
(e) Citizen of foreign country? NO (Yes or No) 7
If yes, name country _____

3. (a) PRINT FULL NAME Frieda Kieffer
3. (b) If veteran, name war None 3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 23
year 1948 hour 6 minute 15 a.m.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Deceased 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased August 20 1887
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 2, 1943, to Mar 23, 1948;
that I last saw her alive on 3-22-48, 1948;
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
60 7 3 hr. min.

Immediate cause of death
Carcinoma of sigmoid with
general metastases
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Quintan - 1943 - Resection sigmoid.
Of operations _____
Of autopsy _____

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation House Work

11. Industry or business _____
12. Name William Schmidt
13. Birthplace Germany
(City, town, or county) (State or foreign country) 4
14. Maiden name Fredericka Alfader
15. Birthplace Germany
(City, town, or county) (State or foreign country) 4

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant Lorraine Kieffer
(b) Address 1100 E. Gano Ave
17. (a) Burial (b) Date thereof 3-26-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation New Bethlehem Cemetery

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? _____

18. (a) Signature of funeral director Math. Hermann & Son, Inc.
(b) Address 2161 E. Fair Ave.
19. (a) MAR 24 1948 (b) J. F. Brodeur
(Date received local registrar's) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury 0
23. Signature Ferguson & Wally (M. D. optional)
Address 10347th & 10th Date signed 3/24/48

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.....

Wilfred H. Buchholz

....., Registered Apprentice No. 1

working under my personal supervision

Signed *William G. Buchholz*

Licensed Embalmer No. 2110

P. O. Address St. Louis Mo

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.