FILED MAY 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17262

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4597

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4514 Wichita Street

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 18 - 4514 Wichita

3. NAME OF DECEASED (Type or Print)
a. (First): Dora
b. (Middle): Mary
c. (Last): Fredrick

4. DATE OF DEATH (Month) (Day) (Year): 5-24-49

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Mar. 3, 1872
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At. Home
11. BIRTHPLACE (State or foreign country): Wayne County, Illinois
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13a. FATHER'S NAME: Jeff Purnell
13b. MOTHER'S MAIDEN NAME: Cynthia Barnhart
14. NAME OF HUSBAND OR WIFE: C.B.Fredrick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): Nil
16. SOCIAL SECURITY NO.: -------
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Lily Standley, 4514 Wichita

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 97
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: 4380

22. *I hereby certify that I attended the deceased from* May 1, 1949, *to* May 23, 1949, *that I last saw the deceased alive on* May 23, 1949, *and that death occurred at* 12:30 A.M. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M. E. Sheets MD
23b. ADDRESS: 4329 Minchester
23c. DATE SIGNED: 5/24/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 5-24-49
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State): Cisne, Illinois

DATE REC'D BY LOCAL REG.: MAY 24 1949
REGISTRAR'S SIGNATURE: J. B. [illegible]
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: A. H. Hoppe, Inc. 4750 Washington St. Louis, Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 .....

..... Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed Clement McNeary

Licensed Embalmer No. 37320

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.