

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21037**

FILED JUL 15 1949

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5403**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY OR TOWN St. Louis		a. STATE Missouri	b. COUNTY 000
d. FULL NAME OF HOSPITAL OR INSTITUTION 4530 St. Louis Ave.		d. STREET ADDRESS (If rural, give location) 4530 St. Louis Ave.	

3. NAME OF DECEASED (Type or Print)	a. (First) Mary	b. (Middle) - - -	c. (Last) Frey	4. DATE OF DEATH (Month) (Day) (Year)
				July 5, 1949.

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH December 10, 1859	9. AGE (In years last birthday) 89	IF UNDER 1 YEAR (Months) 6	IF UNDER 1 YEAR (Days) 25	IF UNDER 1 HRS. (Hours) _____	IF UNDER 1 HRS. (Min.) _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Pittsburg, Pennsylvania	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Philip Waeckerle	13b. MOTHER'S MAIDEN NAME Caroline Hildebrandt	14. NAME OF HUSBAND OR WIFE Robert Frey
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mrs. Carrie McIlvaney	ADDRESS 4530 St. Louis Ave.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral accident		INTERVAL BETWEEN ONSET AND DEATH 14 hrs yes.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
		102

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? HHHX
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22. I hereby certify that I attended the deceased from **Jan. 1942**, to **July 5, 1949**, that I last saw the deceased alive on **July 5, 1949**, and that death occurred at **10:30P.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Arthur Schneider M.D.	23b. ADDRESS 2202 University St.	23c. DATE SIGNED 7/6/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7/8/49	24c. NAME OF CEMETERY OR CREMATORY Valhalla	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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DATE REC'D BY LOCAL REG. JUL 6 1949	REGISTRAR'S SIGNATURE J. B. Lasater	25. FUNERAL DIRECTOR'S SIGNATURE Calvin F. Feutz	ADDRESS 4828 Natural Bridge Blvd.
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

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4-1-19

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 *John A. Mlinar*

Licensed Embalmer No. *4186*

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.