

FILED JAN 16 1950.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2282

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 121

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY 2019	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri-Pacific Hospital		d. STREET ADDRESS (If rural, give location) 3931 Dover Place	
3. NAME OF DECEASED (Type or Print) a. (First) Freda b. (Middle) Louise c. (Last) Bloch		4. DATE OF DEATH (Month) (Day) (Year) Jan. 4, 1950	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 7-21-1892
9. AGE (In years last birthday) 57		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Missouri
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Ewald Uhdau		13b. MOTHER'S MAIDEN NAME Katherine Goler	14. NAME OF HUSBAND OR WIFE Albert L. Bloch
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Albert L. Bloch 3931 Dover Place
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 1 mo. + 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. Rectal Hemorrhage 2 weeks	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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) 82	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 3312	
22. I hereby certify that I attended the deceased from Nov. 28, 1949 , to Jan. 4, 1950 , that I last saw the deceased alive on Jan. 4, 1950 , and that death occurred at 12:30 P. m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) John H. Williams M.D.		23b. ADDRESS St. Louis, Mo. 3128 Henrietta St.	23c. DATE SIGNED 1-4-50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-7-1949	24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	24d. LOCATION (City, town, or county) (State) 10880 Gravois Ave.
DATE REC'D BY LOCAL REG. JAN 6 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS [Signature] 6409 Gravois Ave	

(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

Henry M. Branner

Licensed Embalmer No. 4200

P. O. Address St. Louis

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.