

No. 300  
10-48

FILED APR 25 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 15420  
Registrar's No. 930

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <b>Koch, Mo.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo.</b>	
c. LENGTH OF STAY (in this place) <b>296 days</b>		d. STREET ADDRESS (If rural, give location) <b>4956 Page Blvd.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Robert Koch Hospital</b>			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <b>Frieda</b>	b. (Middle) <b>Mae</b>	c. (Last) <b>Maddux</b>	(Month) <b>April</b>	(Day) <b>9</b>	(Year) <b>1950</b>

5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>2-28-22</b>	9. AGE (In years last birthday) <b>28</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 18 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier</b>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <b>Rector, Arkansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Guy Thorne (deceased)</b>	13b. MOTHER'S MAIDEN NAME <b>Ora Pentecost (deceased)</b>	14. NAME OF HUSBAND OR WIFE <b>Mitchell Maddux</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>431-44-3074</b>	17. INFORMANT'S SIGNATURE OR NAME _____ ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>22 mos. ?</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary Tuberculosis</b>		
	ANTÉCEDENT CAUSES: DUE TO (b) <b>Hodgkins Disease</b> <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>  DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS - <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>			<b>0028</b>

19a. DATE OF OPERATION <b>None</b>	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) <b>none</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____
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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? _____
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22. I hereby certify that I attended the deceased from **6-17-**\_\_\_\_, **1949**, **6-9**\_\_\_\_, **1950**, that I last saw the deceased alive on **4-9-50**, 19\_\_\_\_, and that death occurred at **11/45 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Harold L. Russell, M.D.</b> (Degree or title)	23b. ADDRESS <b>Koch Hospital</b>	23c. DATE SIGNED <b>4-9-50</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>4-10-50</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Koch Hospital</b>	24d. LOCATION (City, town, or county) (State) <b>Rector, Ark.</b>
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DATE REC'D BY LOCAL REG. <b>4-10-50</b>	REGISTRAR'S SIGNATURE <b>Herbert R. Doube, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b> ADDRESS <b>4700 Washington Blvd.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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 Me

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed Ray W. Wilkins

Licensed Embalmer No. 3575

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.**