

FILED NOV 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38473**
9344
Registrar's No.

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
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 2169	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital		d. STREET ADDRESS (If rural, give location) 3644 Tennessee	

3. NAME OF DECEASED (Type or Print) a. (First) Elizabeth b. (Middle) c. (Last) Fierer			4. DATE OF DEATH (Month) (Day) (Year) 11/2/50					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Oct. 21, 1865	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Germany 4		12. CITIZEN OF WHAT COUNTRY? USA		

13a. FATHER'S NAME Peter Freitag		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Louis	
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. ---		17. INFORMANT'S SIGNATURE OR NAME Louis Fierer--3644 Tennessee	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident		ANTECEDENT CAUSES DUE TO (b) ? DUE TO (c)				
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension				
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 33FX	

22. I hereby certify that I attended the deceased from **10-28**, 19**50**, to **11-2**, 19**50**, that I last saw the deceased alive on **11-1**, 19**50**, and that death occurred at **9:20A** m., from the causes and on the date stated above.

23a. SIGNATURE M. B. Rosenberg M.D.		23b. ADDRESS 5689 Bernad		23c. DATE SIGNED 11-3-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11/4/50		24c. NAME OF CEMETERY OR CREMATORY N. St. Marcus	
		24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri			

DATE REC'D BY LOCAL REG. NOV 3 1950		REGISTRAR'S SIGNATURE J. P. ...		25. FUNERAL DIRECTOR'S SIGNATURE Wacker-Heldner		ADDRESS 3634 Gravois	
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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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Frank J. O'Connell Jr.

Signed.....
Student Embalmer

Licensed Embalmer No. *2675*

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.