

FILED DEC 17 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42381

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **11072**

|  |                                  |  |  |  |   |  |
|--|----------------------------------|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |                                  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY |  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN <b>St. Louis</b>  |                                  | c. LENGTH OF STAY (in this place)  | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN <b>St. Louis</b>                          |  | 2269  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital</b>   |                                  |  | d. STREET ADDRESS (If rural, give location)<br><b>26 1415th Hebert St. 0</b>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or Print)   |                                  |  | a. (First) <b>Frieda</b> b. (Middle) <b>M.</b> c. (Last) <b>Feyer</b>  |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>Dec 3 1954</b>                          |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>                               | 8. DATE OF BIRTH<br><b>12-20-1887</b>  | 9. AGE (in years last birthday) <b>69</b>  | IF UNDER 1 YEAR Months Days<br>IF UNDER 24 HRS. Hours Min.                          |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Germany</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |  |
| 13a. FATHER'S NAME<br><b>Gustav Kaufmann</b>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>Mildred Heuster</b>  |  | 14. NAME OF HUSBAND OR WIFE<br><b>Deceased</b>   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, state year or date of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>   | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><b>Mrs. Mildred Doyel 5623 Maple St.</b>  |  |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.        |                                  |  |  |  |   |  |
| MEDICAL CERTIFICATION  |                                  |  |  |  |   |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____   |                                  |  |  |  |   |  |
| ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  |                                  |  |  |  |   |  |
| DUE TO (b) <b>Cerebrovascular</b>  |                                  |  |  |  |   |  |
| DUE TO (c) <b>accident, Hemorrhage</b>   |                                  |  |  |  |   |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>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?<br>YES <input checked="" type="checkbox"/> NO <input 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) m.   |                                  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR?<br><b>331X</b>  |  |   |  |
| 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>320A</b> m., from the causes, and on the date stated above. |                                  |  |  |  |   |  |
| 23a. SIGNATURE (Degree or title)<br><b>Patrik P. Taylor Coroner</b>  |                                  |  | 23b. ADDRESS<br><b>1300 Clark</b>  |  | 23c. DATE SIGNED<br><b>12-14-54</b>   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)  | 24b. DATE<br><b>12-6-54</b>      | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Zion Cemetery</b>   |  | 24d. LOCATION (City, town, or county) (State)<br><b>St. Louis County Mo</b>                        |   |  |
| DATE REC'D BY LOCAL REG.<br><b>DEC 6 1954</b>  |                                  | REGISTRAR'S SIGNATURE<br><b>J. Carl Smith MO</b>   |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>JOHN STYGAR and SON FUNERAL HOME 6574 Riverview</b> |   |  |

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

3412

**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.

Signed \_\_\_\_\_  
Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. *3980*

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.