

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42060**
Registrar's No. **10718**

FILED JAN 6 1956

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		REGISTRAR'S 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. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN ST. LOUIS		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION DePAUL HOSPITAL				e. STREET ADDRESS (If rural, give location) 3514 NO. NEWSTEAD			
3. NAME OF DECEASED (Type or Print) a. (First) CHARLOTTE			b. (Middle) _____		c. (Last) FREY		4. DATE OF DEATH (Month) (Day) (Year) DEC. 6, 1955
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JULY 16, 1897		9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETAIL CLERK		10b. KIND OF BUSINESS OR INDUSTRY DRY GOODS		11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS MISSOURI		12. CITIZEN OF WHAT COUNTRY? U S A	
13a. FATHER'S NAME WILLIAM VOELPEL			13b. MOTHER'S MAIDEN NAME VIOLA BUERLIN		14. NAME OF HUSBAND OR WIFE ALFRED FREY		
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 IRMA OTT			ADDRESS 895 GUSTAV
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Apoplexy					INTERVAL BETWEEN ONSET AND DEATH _____
		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.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 334x				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. ACCIDENT (Specify) SUICIDE HOMICIDE		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 (Month) (Day) (Year) (Hour) OF INJURY _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
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 6:30 A. M. , from the causes and on the date stated above.							
23a. SIGNATURE Robert E. Smith (Degree of title) _____				23b. ADDRESS 1300 Olive		23c. DATE SIGNED 12/7/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE DEC 9, 1955	24c. NAME OF CEMETERY OR CREMATORY NEW ST PAUL CHURCHYARD		24d. LOCATION (City, town, or county) (State) ST LOUIS COUNTY		
DATE REC'D BY LOCAL REG. DEC 7 1955		REGISTRAR'S SIGNATURE Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE _____ ADDRESS: STROOT CARROLL 4600 NATURAL BRIDGE			

(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.....
Signature of Student Embalmer

Signed *M W Rueter*.....

Licensed Embalmer No. *486*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.