

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046302

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11519 STATE FILE NUMBER

FILED DEC 18 1961

1. PLACE OF DEATH
a. COUNTY De
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Missouri
b. COUNTY St. Louis
c. City OR TOWN Florissant
d. STREET ADDRESS (If outside, give location) 1505 St. Denis

Length of stay in lb 25 yrs.
Inside Limits Yes No
Inside Limits Yes No
Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
Mary Rosalie Frauenfelder

4. DATE OF DEATH Month Day Year
12 10 1961

5. SEX Female
6. COLOR OR RACE White
7. Married Never Married
Widowed Divorced

8. DATE OF BIRTH 7-1-1882
9. AGE (last birthday) 79

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10b. KIND OF BUSINESS OR INDUSTRY at home
11. BIRTHPLACE (City and state or country) France
12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Emil Guio
13b. MOTHER'S MAIDEN NAME Mary Finance
14. NAME OF HUSBAND OR WIFE Harry

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 Mrs. Herbert Ullman 1605 St. Denis Florissant Address #120

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) *Coronary atherosclerosis*
DUE TO (b) *Generalized arteriosclerosis*
DUE TO (c) *420-0*

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) *Cerebral Vasculature aneurysm. Embolism.*

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

INTERVAL BETWEEN ONSET AND DEATH 5 yrs.

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour Month, Day, Year
a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1955 to Dec 1961 and last saw her alive on 12-10-61
Death occurred at 1 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE *John B. Meyer M.D.* (Signed or title)
22b. ADDRESS 634 N. Good Blvd.
22c. DATE SIGNED 12-11-61

23a. BURIAL, CREMATION, REMOVAL (Specify) removal
23b. DATE 12-13-1961
23c. NAME OF CEMETERY OR CREMATORY Calvary Madison County Ill
23d. LOCATION (City, town, or county) (State) Edwardsville Township Ill

24. FUNERAL DIRECTOR *Francis A. Deben Madison* ADDRESS
25. DATE RECD. BY LOCAL REG. DEC 11 1961
26. REGISTRAR'S SIGNATURE *Loan Smith, M.D.*

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Frank J. Sehey

Licensed Embalmer No. 2792

P. O. Address Madison

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.