

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

28592

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1000**

City **St. Louis Mo.** (No. **City Infirmary**)

File No.

Registered No. **8498** St. Ward)

2. FULL NAME

(a) Residence, No. **2 1/2 S Walnut** St., **13** Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Aug 15, 1844

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

88

11

23

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

None known

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Sweden

10. NAME OF FATHER

Fred Frederickson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

Sweden

12. MAIDEN NAME OF MOTHER

Mary Jensen

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

Sweden

14. INFORMANT (Address)

**M. E. Pipeker
5800 Grand**

15. FILED **AUG 27 1930** 19

W. C. Standley
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1

16. DATE OF DEATH (MONTH, DAY AND YEAR) **8-7-30** 19

17. I HEREBY CERTIFY, That I attended deceased from **8-7**, 19**30**, to **8-7**, 19**30** that I last saw him alive on **8-7**, 19**30**, and that death occurred, on the date stated above, at **11:20 A.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

**Chronic Hypertensive
Cerebrovascular
Disease**

CONTRIBUTORY (SECONDARY)

90%

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? **No** DATE OF

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) **W. C. Standley**, M. D.

J. S. 1930 (Address) **5600 Grand**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Washington U.

DATE OF BURIAL

8-9 1930

20. UNDERTAKER

Walter Richter

ADDRESS

3500 Rutquist

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

