

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.

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

16582
 Do not use this space.

REC'D JUN 9 1938

1. PLACE OF DEATH
 (a) County.....
 (b) Township.....
 (c) City..... St. Louis
 (e) Length of residence in city or town where death occurred yrs. mos. 14 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registration District No. 791
 Primary Registration District No. 1003
 (d) Street No. St. Lukas Hospital St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)

Registered No. 4443

2. PRINT FULL NAME Mildred Friedrich *636*

(a) Residence, No. Owensville, Mo. St. NR Owensville, Mo.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 30, 1913		
7. AGE YEARS 24	MONTHS 11	DAYS 13
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Stenographer		
9. Industry or business in which work was done, as saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Casco, Mo.		
FATHER	13. NAME Fred Friedrich	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany	
MOTHER	15. MAIDEN NAME Lydia Freiberger	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clover Bottom, Mo.	
17. INFORMANT F. C. Friedrich (ADDRESS) Owensville, Mo.		
18. BURIAL, CREMATION, OR REMOVAL PLACE Owensville, Mo. DATE 5-16 , 19 38		
19. FUNERAL DIRECTOR (NAME) Albert H. Hoppe Inc. (ADDRESS) 429 North Euclid Ave.		
20. FILED MAY 14 1938 <i>J. B. ...</i> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **5-13**, 19**38**

22. I HEREBY CERTIFY, That I attended deceased from **4-25**, 19**38** to **5-13-38**, 19**38**.
 I last saw her alive on **5-13**, 19**38**. Death is said to have occurred on the date stated above, at **2:00 P.M.**
 The principal cause of death and related causes of importance were as follows:
Cellular Tumor 5 1/2" x 1 1/2" x 1 1/2"
Brain
 Date of onset _____

Other contributory causes of importance *None.*
Craniotomy
 removal of tumor.
 Name of operation *Craniotomy with/* Date of **4-30-38**
 What test confirmed diagnosis? _____ Was there an autopsy? *No.*

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19**38**
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____ (Signed) *A. M. ...*, M. D.
 (Address) *Bourbon Alley.*

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,

Albert V. Hoppe

, or by

Registered Apprentice No. _____, working under my personal supervision.

Signed

Albert V. Hoppe

Licensed Embalmer No. _____

P. O. Address _____

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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, above space should be left blank.