

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.

JAN 12 1940 791  
Registration District No. 791

Primary Registration District No. \_\_\_\_\_

Registrar's No. 10778

1. PLACE OF DEATH: ICUWS  
(a) County 1  
(b) City or town \_\_\_\_\_  
(c) Name of hospital or institution: City Hospital  
(If not in hospital or institution, write street number or location):  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days) 636

8. (a) PRINT FULL NAME: ROBERT FREDERITZ  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex: MALE 5. Color or race: WHITE 6. (a) Single, widowed, married, divorced: Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: 11 - 27 - 1939  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: St. Louis, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation: nil

11. Industry or business: nil

MOTHER FATHER  
12. Name: Edwin Frederitz  
13. Birthplace: \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name: Verna Carr  
15. Birthplace: St. Louis, Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature: David Van Fossen  
(b) Address: City Hosp morgue

17. (a) removal (b) Date thereof: 12-18-39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Winnemucca

18. (a) Signature of funeral director: Healy's Funeral Home  
(b) Address: Winnemucca, Mo.

19. (a) DEC 18 1939 (b) J. B. Bulech  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State: Mo (b) County: 1  
(c) City or town: St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No.: 7202 Virginia  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 16  
year 1939 hour 1 minute 15 PM.  
21. I hereby certify that I attended the deceased from 12-16-39  
\_\_\_\_\_, 19\_\_\_\_, to: 12-16-39, 19\_\_\_\_;  
that I last saw him alive on 12-16-39, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Septicemia  
Peritonitis  
Due to: Omphalitis  
Due to: \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death): \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: \_\_\_\_\_  
Duration: 2 days  
PHYSICIAN: \_\_\_\_\_  
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place)  
(e) Means of injury: \_\_\_\_\_  
23. Signature: E. E. Nebleman (M.D. or other)  
Address: 1515 Lafayette Date signed: 12/16/39

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**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.....

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.**