

Registration District No. 425

Primary Registration District No. 5580

Registrar's No. 14-39

1. PLACE OF DEATH:

(a) County JEFFERSON
(b) City or town RURAL - MERAMEC
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Joseph's Hill Infirmary
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County _____
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 5019 MAPLE AVE
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME JOSEPH W. FROMEYER

3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife CATHERINE FLATLEY 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 3 19 1857
(Month) (Day) (Year)

8. AGE: Years 83 Months 5 Days 13 If less than one day _____ hr. _____ min.

9. Birthplace CINCINNATI OHIO
(City, town, or county) (State or foreign country)

10. Usual occupation SALESMAN (RETIRED)

11. Industry or business BOILER COMPOUND MFG.

12. Name WILLIAM

13. Birthplace GERMANY
(City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN

15. Birthplace GERMANY
(City, town, or county) (State or foreign country)

16. (a) Informant Brother Rock

(b) Address St. Joseph's Hill Infirmary

17. (a) BURIAL (b) Date thereof 9 5 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director J. M. Malley

(b) Address 5165 Delmar Blvd

19. (a) 3 Sep 1940 (b) James O. Townsend
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 2nd
year 1940 hour Seven minute _____ A.M.

21. I hereby certify that I attended the deceased from August 24th, 1940, to Sept. 1st, 1940, that I last saw him alive on Sept. 1st, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Interstitial Nephritis

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 _____

Signature Jesse S. Sargent (M. D. or other) _____

Address Evreka, Mo. Date signed 9/3/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE 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.....

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

Signed.....

John Ketter

Licensed Embalmer No. *3880*

P. O. Address *St. Louis Mo.*

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, fact should be so stated above.