

No. 2
-5-43
-17-39
X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4239

FILED FEB 16 1945

State File No. _____

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 1109

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County.....

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
6642 1/2 Virginia ave.
(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

3. (a) PRINT FULL NAME Clementine Fritz

3. (b) If veteran, name war. No

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife. George Fritz

6. (c) Age of husband or wife if alive. 1863 years

7. Birth date of deceased. January 6
(Month) (Day) (Year)

8. AGE: Years 82 Months 0 Days 27
If less than one day
hr. _____ min. _____

9. Birthplace St. Louis Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER

12. Name Clement Pidgeon

13. Birthplace St. Louis Mo. 0
(City, town, or county) (State or foreign country)

14. Maiden name Antoinette TAYON

15. Birthplace St. Louis Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mary Robertson

(b) Address 4101 Concordia ave.

17. (c) Burial (b) Date thereof. Feb. 6, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
Mt. Hope Cemetery

(c) Place: burial or cremation _____

18. (a) Signature of funeral director C. Hoffmeister U. & L. Co.
7814 S. Broadway

(b) Address _____

19. (a) FEB 5 1945 J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17

(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 9
6424 Virginia ave.

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 3
year 1945 hour 5 minute 05 a.m.

21. I hereby certify that I attended the deceased from
Jan. 29, '44. to Feb. 3, 1945.
that I last saw her alive on Feb. 2, 1945.
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchpneumonia Duration 5 days

Due to _____

Due to Senility. 107

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: None.

Of operations _____

Of autopsy None.

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 D. S. Smith (M. D. or other)
Address 6006 Virginia Ave. Date signed 2/3/45.

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 *Linus C. Hoffmeister*

Licensed Embalmer No. *3871*

P. O. Address *7814 S. Broadway*

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.