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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED OCT 16 1946
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 8610

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis

(c) Name of hospital or institution: Missouri Baptist
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days
(Specify whether In this community _____ years, months or days)

3. (a) PRINT FULL NAME Jane Frintrup

3. (b) If veteran, name war no

3. (c) Social Security No. 499 12 9445

4. Sex female / 5. Color or race white

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

6. (b) Name of husband or wife William A. Frintrup

6. (c) Age of husband or wife if alive 26 years

7. Birth date of deceased April 21 1915
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>31</u>	<u>5</u>	<u>14</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Robert Bohler

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

14. Maiden name Ann Rowan

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

16. (a) Informant Wm A. Frintrup

(b) Address 5359 Wilburn Dr.

17. (a) Burial (b) Date thereof 10 5 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Joe Quinn

(b) Address 1389 Union Blvd.

19. (a) OCT 7 1946 (b) J. T. Bredek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County St. Louis

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

(d) Street No. 5359 Wilburn Dr.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 5th year 1946 hour 1 ⁷⁵ pm minute _____ M.

21. I hereby certify that I attended the deceased from MAY 6th - 1946, 19____, to October 5, 1946, that I last saw h. ER alive on Oct 5, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death: _____

1. Tuberculosis - Bilateral

2. Pre Eclampsic Toxemia

Due to _____

(2) Pregnancy

Due to _____

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

Major findings: _____

Of operations CAESARIAN SECTION TO SAVE CHILD

Of autopsy Tuberculosis
Pre Eclampsia

Duration _____

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 John B O'Neil (M. D. or other) _____

Address 1322 Missouri Theatre Date signed 10/7/46

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 Ronald J. Chabe
Licensed Embalmer No. 3917
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, fact should be so stated above.