

FILED MAY 29 1947 **318**

Primary Registration District No. **1003**

WRITE PLAINLY—USING 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: **Missouri Baptist Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **17 days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **2 4801 Milentz**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Frieda Gahn**

3. (b) If veteran, name war.....
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 **Herman J.**
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **September 10th, 1882**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 8 9 hr. min.

9. Birthplace **O'Fallon Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **home**

11. Industry or business.....

12. Name **Henry Gabel**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Edwin Gahn**

(b) Address **3021 Capehart, Normandy, Mo.**

17. (a) **burial** (b) Date thereof **May 21, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: **old SS Peter & Paul Cemetery**

18. (a) Signature of funeral director **Wacker-Kelley N. & P. Co.**
(b) Address **3634 Gravois St. Louis, Mo.**

19. (a) **MAY 20 1947** (b) **J. F. Brebeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **19th**
year **1947** hour **7** minute **15 A.** M.

21. I hereby certify that I attended the deceased from **2-10-47** to **5-19-47**
that I last saw her alive on **5-19-47**, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death: **Thrombosis Abdominal aorta at level of iliac bifurcation**
Due to **hypertension and atherosclerosis**
Due to **thrombosis of abdominal aorta**
Other conditions (Include pregnancy within 3 months of death)
Coronary artery disease

Major findings: **Coronary artery disease**
Of operations.....
Of autopsies.....
PHYSICIAN **J. F. Brebeck**
Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the INFORMATION REQUESTED
(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?..... (Specify type of place)

While at work?..... (e) Means of injury **fall**

23. Signature **R. K. Anderson** (M. D. or other) **J. F. Brebeck**
Address **1933 Maryland** Date signed **5-19-47**

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.....

Robert Wheeler

Licensed Embalmer No.....

2128

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18844
Registrar's No. 5034

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 5034

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(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 Frieda Gahn

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 64 Months 8 Days _____ (If less than one day, _____ min.)

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4-9-48 (b) J. F. Brudest
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____

that I last saw him _____ alive on _____ 19 _____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to Arteriosclerosis

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 _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

