No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 28 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39666

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10601

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State: Illinois (b) County: 999
(c) City or town: Granite City 11 (If outside city or town limits, write "RURAL")
(d) Street No. 2401 Delmar 2 (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: William A Frey
3. (b) If veteran, name war: —
3. (c) Social Security No.: —
4. Sex: Male 1
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married 1
6. (b) Name of ~~husband or~~ wife: Dosha
6. (c) Age of ~~husband or~~ wife if alive: 55 years
7. Birth date of deceased: Oct (Month) - 10 (Day) - 1891 (Year)

8. AGE: Years 56 | Months 1 | Days 6 | If less than one day: hr. min.

9. Birthplace: Gillespie (City, town, or county) Ill. 1 (State or foreign country)
10. Usual occupation: Merchant
11. Industry or business: Own Store
FATHER
12. Name: William Frey
13. Birthplace: Gillespie (City, town, or county) Ill. 1 (State or foreign country)
MOTHER
14. Maiden name: Hattie Oldewurtle
15. Birthplace: Gillespie (City, town, or county) Ill 1 (State or foreign country)
16. (a) Informant: Mrs Dosha Frey
(b) Address: 2401 Delmar Av. Granite City Ill.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 11 (Month) - 17 (Day) - 1947 (Year)
(c) Place: burial or cremation: Sunset Hill Cem Edwardsville Ill.
18. (a) Signature of funeral director: Rowland Funeral Svc.
(b) Address: 4356 Washington Av.
19. (a) NOV 18 1947 (Date received local registrar) (b) J. J. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 16 year 1947 hour 12 minute 10 A.M.
21. I hereby certify that I attended the deceased from Oct 30, 1947 to Nov 16, 1947 that I last saw him alive on Nov 16, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of splenic flexure of colon	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations:
Of autopsy:

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature: J R Bradley (M. D. ~~or other~~)
Address: Barnes Hospital Date signed 11/16/47

(Licensed Embalmer's Statement on Reverse Side)

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 Yahnke.....

Licensed Embalmer No.....3917.....

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.