

FILED MAY 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17267

#97573

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

State File No.

Registrar's No. 4450

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri. (1)		c. CITY (If outside corporate limits) write RURAL and give township) OR TOWN St. Louis (1)	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 17 2107 S. Grand (1)	
3. NAME OF DECEASED (Type or Print) a. (First) BERTHA b. (Middle) c. (Last) FROMMANN		4. DATE OF DEATH (Month) (Day) (Year) May 17, 1949	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 24, 1867
9. AGE (In years last birthday) 81		10. CITIZENSHIP (If under 14 years, of what country) St. Louis, Missouri (1)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
13a. FATHER'S NAME Charles Keppler		13b. MOTHER'S MAIDEN NAME Catherine Lippert	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Othelia Frommann 2107 S. Grand Bl.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peronephric Abscess ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Diabetes Mellitus DUE TO (c) Uremia II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 61	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 260X		22. I hereby certify that I attended the deceased from 5/16/49 19 to 5/17/49 19, that I last saw the deceased alive on 5/17/49 19, and that death occurred at 6:45 PM, from the causes and on the date stated above.	
23a. SIGNATURE Joe H. Hardin D.M.D. (Degree or title)		23b. ADDRESS 1515 Lafayette Ave.,	
23c. DATE SIGNED 5/18/49		24a. BURIAL: CREMATION, REMOVAL (Specify) Burial	
24b. DATE 5-20-1949		24c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cemetery St. Louis, Mo.	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE Weick Bro. Und. Co. 2201 S. Grand	
DATE RECEIVED BY LOCAL REG. MAY 19 1949		REGISTRAR'S SIGNATURE J. B. Fusler	

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

MAY 19 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____
Student Embalmer

Signed _____

Licensed Embalmer No. 4953

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.