

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32449

State File No.

FILED OCT 16 1951

BIRTH NO. _____		REG. DIST. NO. <u>4</u>		PRIMARY REG. DIST. NO. <u>4012</u>		Registrar's No. <u>64</u>	
1. PLACE OF DEATH a. COUNTY <u>Athens</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Athens</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rock-Port mo</u>		c. LENGTH OF STAY (in this place) <u>11 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rock-Port mo 0030</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location) <u>0</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>George</u>			b. (Middle) <u>Edward</u>		c. (Last) <u>Frede</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 29 -- 1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Dec - 18 - 1884</u>	9. AGE (in years last birthday) <u>66</u>	10 UNDER 1 YEAR Days <u>9</u>	11 UNDER 12 Hrs. Hours <u>11</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13a. FATHER'S NAME <u>Joseph Frede</u>			13b. MOTHER'S MAIDEN NAME <u>Becken</u>		14. NAME OF HUSBAND OR WIFE <u>Lois Eymann Frede</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Lois Frede - Rock-Port mo</u>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic myocarditis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>About 2yr</u>
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)			
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? <u>9/28</u>			
22. I hereby certify that I attended the deceased from <u>11/30</u> , 19 <u>50</u> , to <u>9/28</u> , 19 <u>51</u> , and that death occurred at <u>2. A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>H. G. ...</u> (Degree or title) <u>0</u>				23b. ADDRESS <u>M.D. Rockport, Mo.</u>		23c. DATE SIGNED <u>Oct. 2, 1951</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>Oct. 1 - 1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>High Creek Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Rock-Port mo</u>	
DATE REC'D BY LOCAL REG. <u>Oct 4, 1951</u>		REGISTRAR'S SIGNATURE <u>Marvin W. Schaefer</u> <u>403</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. E. ... Rock Port Mo</u>			

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

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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 _____

C. E. Burton

Student Embalmer No. _____

working under my personal supervision.

Signed *C. E. Burton*

Signed _____
Student Embalmer

Licensed Embalmer No. *1764*

P. O. Address *Rosh Post 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.