MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis (No. Art Museum ..... St. ..... Ward)

File No. 2944

Registered No. E 530

2. FULL NAME William L. Freeman

(a) Residence. No. 4020 Westminster St. 19 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Josephine S. Freeman

6. DATE OF BIRTH (MONTH, DAY AND YEAR): June 12-1847

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
79	7	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Information Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Art Museum
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): Sciverport
(STATE OR COUNTRY): Louisiana

PARENTS

10. NAME OF FATHER: Wm T. Freeman
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Virginia
12. MAIDEN NAME OF MOTHER: Theresa Eldridge
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Kentucky

14. INFORMANT: Mary S. Mackey
(Address): 6910 Pershing

15. FILED JAN 16 1927 19 Mary C. Starkloff REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jany 14 1927

17. I HEREBY CERTIFY, That I attended deceased from Jany 14, 1927, to Jany 14, 1927, that I last saw him alive on Jany 14, 1927, and that death occurred, on the date stated above, at 8 30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Haemorrhage
82R Apoplexy
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Arterial Sclerosis
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? N/A
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? Pulse + age.

(Signed) P. J. Sauer, M. D.
1/14, 1927 (Address) Mo Bldg.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Bellefontaine
DATE OF BURIAL: 1-17-1927

20. UNDERTAKER: Wagoner
ADDRESS: 3621 Olive

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.