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

Do not use this space.

29025

File No. .....
Registered No. 8608

1. PLACE OF DEATH

County.....
Township.....
City St Louis (No. City Infirmary St. .....Ward)

Registration District No. 791
Primary Registration District No. 1003

2. FULL NAME John Freeman

(a) Residence. No. 545 So Ewing St., 13 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Born abt 1849

7. AGE abt 78

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

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer 82
(b) General nature of industry, business, or establishment in which employed (or employer) 107
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Miss
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Unk
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unk
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Unk
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unk
(STATE OR COUNTRY)

14. INFORMANT Mrs M Effinger
(Address) City Infirmary

15. FILED SEP 27 1927 19 Max C Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 3 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug. 21, 1927, to Sept. 3, 1927, that I last saw h.r.m. alive on Sept. 3, 1927, and that death occurred, on the date stated above, at 5:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy Cerebral Hemorrhage
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (SECONDARY) Bronchial pneumonia
(duration) yrs. mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) R. L. Lanman, M. D
, 19 (Address) City Infirmary

*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.

Removed to St Peters 10-6-27

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Washington | DATE OF BURIAL 9/9 19 27

20. UNDERTAKER Jerome Ellis W. Richter | ADDRESS 3810 Olive 2500 Rutger

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.

WARNING INK—THIS IS A PERMANENT RECORD