

REG JUN 15 1940
Registration District No. 791

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 1421 Goodfellow Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7
(Specify whether years, months or days) 75 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1421 Goodfellow Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME MRS HANNAH FREEMAN

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Lute Thomas Freeman 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 15-1865
(Month) (Day) (Year)

8. AGE: Years 75 Months 3 Days 16 If less than one day hr. _____ min. _____

9. Birthplace Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business _____

12. Name Graham

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Kelly Beryne

(b) Address 1421 Goodfellow

17. (a) Burial (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation De Soto, Mo.

18. (a) Signature of funeral director Henry Ludwig U.C.B.

(b) Address 1417 N. Market St.

19. (a) MAY 2 1940 (b) _____

(Date received local registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1st
year 1940 hour 4 minute 25 P. M.

21. I hereby certify that I attended the deceased from Feb. 10-40
May 1 1940 to May 1 1940
that I last saw her alive on May 1 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic heart hypertrophy
with irregular gallop

Due to _____
Due to _____

Other conditions Lactitis
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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?

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature F. W. Green (M. D. or other)
Address 11900 Union St. Date signed 5/1/40

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

*Dr. Kinloch
Nashville, Tenn.*

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 Homer L. Ponder

Licensed Embalmer No. 3267

P. O. Address 2223 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, above space should be left blank.