

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

16839

State File No. \_\_\_\_\_

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 4317

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Homer G Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10 days  
In this community 22 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St Louis 22  
(If outside city or town limits, write "RURAL")  
(d) Street No. 820 S 10th  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years

3. (a) PRINT FULL NAME ANNA FREEMAN 655

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

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

6. (b) Name of husband or wife William Freman 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased Nov, 22nd, 1897  
(Month) (Day) (Year)

8. AGE: Years 42 Months 5 Days 24 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Henry Thomas  
18. Birthplace Jackson Ga.  
(City, town, or county) (State or foreign country)

14. Maiden name Tassie Simms  
15. Birthplace Ga.  
(City, town, or county) (State or foreign country)

16. (a) Informant H. Phillips Dickson  
(b) Address 820 South 10th, St.

17. (a) Burial (b) Date thereof 5-18-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Father Dickson Cem.

18. (a) Signature of funeral director Ellis Fun, Home  
(b) Address 2820 Stoddard St

19. (a) MAY 15 1940 (b) J. F. Budich  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12  
year 1940 hour 9:10 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from May 2, 1940 to May 12, 1940;  
that I last saw her alive on May 12, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease 2-3yrs  
Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN  
\_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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 H. J. Lynam (M. D. or other) \_\_\_\_\_  
Address 2601 N Whittier Date signed \_\_\_\_\_

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

MOTHER FATHER

**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 *J. K. Murphy*

....., Registered Apprentice No. *Murphy*  
working under my personal supervision.

Signed *Lomnie Boykin*  
Licensed Embalmer No. *297*  
P. O. Address *St. Louis*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**