

791

1003

Registration District No. _____ Primary Registration District No. _____

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

19

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 St. Louis City Hospital # 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days
In this community 60 Years.
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis. 26
(If outside city or town limits, write "RURAL")
(d) Street No. 3225 No. Florissant Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Mary Freesmeier.

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

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

6. (b) Name of husband or wife Frank Freesmeier. 6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased October 31, 1864
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>1</u>	<u>26</u>	<u>hr.</u> <u>6</u> min.

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

10. Usual occupation At Home.

11. Industry or business _____

12. Name John Genail.

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

14. Maiden name Elizabeth Bittenhouse.

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

16. (a) Informant Frank Freesmeier.

(b) Address 3225 No. Florissant Ave.

17. (a) Burial (b) Date thereof 12-28-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd

19. (a) DEC 28 1940 (b) J. F. Bredeck
(Date by which registered) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 26th.
year 1940 hour 3:45 minute P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

*Fracture of Ulna fracture of Radius
Subarachnoid hemorrhage suffered
when deceased fell down a flight
Due to of stairs at the Little Sisters
of the poor 3225 No. Florissant
Ave. St. Louis Dec 26th 1940
exact time unknown*

Other conditions _____
(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) Accident
(b) Date of occurrence Dec 26 1940
(c) Where did injury occur? St. Louis Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Little Sisters of the poor home
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Thomas F. Callahan (M. D. or other) _____
Address Deputy Coroner Date signed 12/27/40

PHYSICIAN

Underline the cause to which death should be charged statistically.

*186a
18*

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

Stanley Marshall

Licensed Embalmer No.

2868

P. O. Address

3840 Russell Blvd

- 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.