

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28638

State File No. _____

Registrar's No. 216

FILED AUG 21 1944

306

6048

1. PLACE OF DEATH

(a) County... *St. Charles*

(b) City or town... *Wentzville Rural* *Wardensville*
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community... *60 years* (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State... *Mo* County... *St. Charles*

(c) City or town... *Wentzville*
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? *No* (Yes or No)

If yes, name country: _____

3. (a) PRINT FULL NAME *Clemence Casper Freymuth*

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *July* day *9* year *1944* hour *4:00* minute *15* M.

21. I hereby certify that I attended the deceased from *now* _____ 19*44* _____ 19*44*

that I last saw him alive on *7/7* _____ 19*44* _____ 19*44* and that death occurred on the date and hour stated above.

4. Sex *Male* 5. Color or race *White* 6. (a) Single, widowed, married *Widowed* 2 divorced

6. (b) Name of husband or wife *Rainera Freymuth* 6. (c) Age of husband or wife *Now* *4* *1860* (Month) (Day) (Year)

7. Birth date of deceased _____

Immediate cause of death *Myocardial degeneration* Duration _____

Due to _____

Due to _____

8. AGE: Years *83* Months *8* Days *3* If less than one day hr. _____ min. _____

9. Birthplace *Josephville Mo* (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) *gpd*

Major findings: Of operations _____

Of autopsy _____

10. Usual occupation *farmer*

11. Industry or business _____

12. Name *Adolph Freymuth*

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

14. Maiden name *Brass*

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

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? _____

16. (a) Informant *Peter Freymuth*

(b) Address *Wentzville, Mo.*

17. (a) *Burial* (Burial, cremation, or removal) (b) Date of report *July 9 1944* (Month) (Day) (Year)

(c) Place: burial or cremation *Wardensville, Mo.*

18. (a) Signature of funeral director *T. B. Peterson*

(b) Address *Wentzville, Mo.*

19. (a) *July 11-44* (Date received local registrar) (b) *E. A. Kitchley* (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature *H. P. W. Murray* (M.D. or other) *MO*

Address *Wentzville* Date signed *7/10*

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

MOTHER FATHER

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

682

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 8-17-44.....

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 *J. E. Pilman*.....

Licensed Embalmer No. 2711.....

P. O. Address *Wentzville, 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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept.

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Charles
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether
In this community 60 yr. years, months or days)

3. (a) PRINT FULL NAME Clemence C. Fraymuth

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

4. Sex m (5. Color or race white) 6. (f) Single, widowed, married, divorced

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

7. Birth date of deceased Nov. (Month) 1900 (Day) (Year)

8. AGE: Years 83 Months 8 Days (If less than one day, min.)

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July year 1944 hour 10 minute 00 M.

21. I hereby certify that I attended the deceased from 19.....
that I last saw h..... alive on 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Of operations

Of autopsy

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 (M. D. or other)

Address Date signed

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

SUPPLEMENTAL

28638