

FILED MAY 10 1945

Registration District No. 4456

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

1. PLACE OF DEATH: St. Clair

(a) County Appleton City

(b) City or town Appleton City  
(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 3 years  
years, months or days)

3. (a) PRINT FULL NAME Karl Freyer

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Nellie Freyer

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased September 6 1869  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

75 7 4 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farming

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

MOTHER FATHER { 12. Name Frederick Freyer

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

14. Maiden name WILHELM GRAFFE

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

16. (a) Informant Nellie Freyer

(b) Address Appleton City Missouri

17. (a) Burial (b) Date thereof 4-12-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Appleton City Mo

18. (a) Signature of funeral director Osceola Funeral Home

(b) Address Osceola Missouri

19. (a) Apr. 12-45 (b) Jane M. Hill  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Cl 93

(c) City or town Appleton City (Rural) 0  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10  
year 1945 hour 8 minute 30 A.M.

21. I hereby certify that I attended the deceased from July 1 1945 to April 10 1945  
that I last saw him alive on April 5 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure  
Coronary thrombosis  
Atrial fibrillation  
Arterial sclerosis

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

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

Other conditions (Include pregnancy within 3 months of death)

Major findings: None

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)

(c) Means of injury \_\_\_\_\_

23. Signature R. L. Hansen (M. D. or other) MD

Address Appleton City Mo Date signed 4-13-45

RECEIVED

District Health Officer No. 71

District File Number 4-45-370

Date Filed 5-9-45

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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. B. Goodrich

Licensed Embalmer No. 3038

P. O. Address Osceola 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.