

No. 2
5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25647**
Registrar's No. **7579**

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL," and name of township)
(c) Name of hospital or institution:
Ho mer G. Phillips Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 days**
In this community **17 years**
years, months or days (Specify whether)

3. (a) PRINT FULL NAME **Dave Freeman**

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

4. Sex **Male 2** 5. Color or race **Colored** 6. (a) Single, widowed, married, divorced **Single 0**

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

7. Birth date of deceased **December 30, 1887**
(Month) (Day) (Year)

8. AGE: Years **57** Months **7** Days **24** If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name **Henry Freeman**

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

14. Maiden name **Nancy Harding**

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

16. (a) Informant **Shirley M. Smith**

(b) Address **Homer G. Phillips Hospital**

17. (c) **Burial Anatomical Board 30/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (d) Signature of funeral director **W. R. ...**

(b) Address _____

19. (a) **AUG 30 1945**
(Date received local authority) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **00**
(c) City or town **St. Louis,** **17 20**
(If outside city or town limits, write "RURAL")
(d) Street No. **1720 N. Glasgow** **9**
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **24,**
year **1945** hour **7** minute **00 P. M.**

21. I hereby certify that I attended the deceased from **August 20,** 19 **45,** to **August 24,** 19 **45;**
that I last saw h. **im** alive on **August 24,** 19 **45;**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Far advanced pulmonary tuberculosis** Unk.
Duration _____

Due to _____

Due to **13 1/2**

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 **P. J. ...** (M. D. or other) _____

Address **2601 N. ...** Date signed **8/24/45**

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

DEC - 5 1945

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. Sept
Registrar's No. 7579

Registration District No. _____

Primary Registration District No. _____

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

3. (a) PRINT
FULL NAME Paul Freeman

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

4. Sex m 5. Color or race B 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased see 3 (Month) 3 (Day) 1958 (Year)

8. AGE: Years 57 Months 7 Days _____ (Less than one day) _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
 (Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) J. F. Bredick
 (Date received local registrar) (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 Sept
 year 1958 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;
 that I last saw him 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)

Major findings:
 Of operations _____

Of autopsy _____

PHYSICIAN

Underline
 the cause to
 which death
 should be
 charged sta-
 tistically.

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

1945
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