

1-5-43  
5-17-39  
I X36671

**FILED** JUN 12 1946

State File No. ....  
Registrar's No. **83**

Registration District No. .... Primary Registration District No. ....

**1. PLACE OF DEATH:**

(a) County Lawrence

(b) City or town Mt. Vernon *7100*  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Missouri State Sanatorium *0*  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 52 days  
(Specify whether years, months or days)

In this community 52 days

**3. (a) PRINT FULL NAME** Freeda Eggegan

3. (b) If veteran, name war No

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 Henry Eggegan

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Oct. 19 1894  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>51</u>	<u>7</u>	<u>1</u>	hr. min.

9. Birthplace Verona Missouri *0*  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

**MOTHER, FATHER**

12. Name Gottfried Yenne

13. Birthplace Switzerland 5  
(City, town, or county) (State or foreign country)

14. Maiden name Katherine Suess

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

16. (a) Informant E. McMichael, Record Clerk

(b) Address Mo. State San. Mt. Vernon, Mo.

17. (a) 5/20/46 (b) Date thereof 5/20/46  
(Date of death, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation VERONA MO

18. (a) Signature of funeral director V.F. KING

(b) Address AURORA MO.

19. (a) 5/20/46 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Lawrence 55

(c) City or town Verona 0  
(If outside city or town limits, write "RURAL")

(d) Street No. Route 2 0  
(If rural, give location) 0

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May day 20th  
year 1946 hour 6:00 minute P M.

21. I hereby certify that I attended the deceased from March 30, 1946 to May 20, 1946;  
that I last saw her alive on May 20, 1946;  
and that death occurred on the date and hour stated above.

Immediate cause of death Metastatic carcinoma 1 yr

Duration

Due to

Due to

**ADDITIONAL SUPPLEMENTARY INFORMATION**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Metastatic carcinoma of skin, chest wall + pleura, liver, Hydropericardium, left Thrombophlebitis, st. chae vein +

PHYSICIAN QUESTED

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: venae cava

(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?

(Specify type of place)

While at work? 0 (c) Means of injury 0

23. Signature P.A. Brasher M.D. (M. D. or other)

Address May 20, 1946 Mt. Vernon, Mo. Date signed

159

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

RECEIVED

District Health Officer No. 6,

District File Number 646-664

Date Filed JUN 11 1946

---

---

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 T King  
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. JuneRegistration District No. 283Primary Registration District No. 5655Registrar's No. 43

## 1. PLACE OF DEATH:

(a) County Lawrence  
(b) City or town My Vietnam Army  
(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 Frieda Eggeman

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

4. Sex F 5. Color or race W 6. (a) 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. Oct 19 (Month) (Day) (Year)8. AGE: Years 51 Months Days If less than one day hr. min.9. Birthplace (City, town, or county) (State or foreign country) MO

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) Address17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)  
(c) Place: burial or cremation18. (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 May 12<sup>o</sup>  
year 1946 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19

that I last saw him alive on and that death occurred on the date and hour stated above.  
Immediate cause of deathDue to Carcinoma left breastDue to breast

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy 50

## 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 (M. D. or other)

Address Date signed

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

16069

SUPPLEMENTARY

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

PHYSICIAN

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

