

FILED JAN 29 1949

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **2641**
 Registrar's No. **418**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital,		d. STREET ADDRESS (If rural, give location) 3514 Sidney St.	

3. NAME OF DECEASED (Type or Print) a. (First) William Fremond b. (Middle) Emery c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Jan. 13 1949		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	
8. DATE OF BIRTH April 8, 1890		9. AGE (In years last birthday) 58		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. BIRTHPLACE (State or foreign country) International Shoe Holbrook, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Charles Emery		13b. MOTHER'S MAIDEN NAME Josephine Crouch		14. NAME OF HUSBAND OR WIFE None	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 488-07-8551		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Evelyn L. Emery New Bedford Mass	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 25+ years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Stenosis resulting in Cardiac decompensation		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic rheumatoid arthritis of childhood		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 92 11/11		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR	
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22. I hereby certify that I attended the deceased from **Jan. 8**, 19 **49**, to **Jan. 13**, 19 **49** that I last saw the deceased alive on **Jan. 13**, 19 **49**, and that death occurred at **1:45 Am.**, from the causes and on the date stated above.

23a. SIGNATURE B. John Frazzetta M.D.		23b. ADDRESS Barnes Hospital,		23c. DATE SIGNED 1/13/49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 1/15/49		24c. NAME OF CEMETERY OR CREMATORY WENDELL - Holbrook Mass	
				24d. LOCATION (City, town, or county) (State) By Rail to Boston Mass	

DATE REC'D BY LOCAL REG. JAN 14 1949		REGISTRAR'S SIGNATURE J. B. Lassiter		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Cullen Kelly 4386 Lindell Blvd.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....

..... Student Embalmer No.

working under my personal supervision.

Signed.....

James A. Lammers

Licensed Embalmer No. *4142*

P. O. Address *St. Louis*

Signed.....
Student Embalmer

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.