

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **43989**

FILED DEC 28 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **210** PRIMARY REG. DIST. NO. **3058** Registrar's No. **23**

1. PLACE OF DEATH a. COUNTY <b>St Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St Charles</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St Charles</b>		c. CITY OR TOWN <b>St Charles</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <b>50 yrs</b>		e. STREET ADDRESS (If rural, give location) <b>205 North 6th St</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION. <b>St Joseph Hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Dr Will</b> b. (Middle) <b>Loren</b> c. (Last) <b>Freeman</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 22 1953</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>March 29 1869</b>	9. AGE (In years last birthday) <b>84</b>	10. F UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>M.D.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>Charles Freeman</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Carter</b>		14. NAME OF HUSBAND OR WIFE <b>Helen Freeman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes World War 2</b>		16. SOCIAL SECURITY NO. <b>World War 2</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Helen Freeman 205 No. 6th St</b>	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>17 days</b> <b>10 years</b> <b>17 days</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>gen. arterio sclerosis</b>		
	DUE TO (c) 11. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death. <b>Rt Hemiplegia</b>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>331X</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	---	---

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Dec 13 1953** to **12-22-53**, that I last saw the deceased alive on **12-22-1953**, and that death occurred at **12:22 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>[Signature]</b>	(Degree or title) <b>M.D.</b>	23b. ADDRESS <b>St Charles Mo</b>	23c. DATE SIGNED <b>Dec 23 1953</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Dec. 24 1953</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St Charles Mo.</b>

DATE REC'D BY LOCAL REG. <b>Dec 26 1953</b>	REGISTRAR'S SIGNATURE <b>Tammie Hamilton</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Arthur C. Paul Funeral Home</b>
--	---	--

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

JAN 4 1934

RECEIVED

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..

Student.....  
Signature of Student Embalmer

Signed *Clarence M. Billo*.....

Licensed Embalmer No. *4375*.....

P. O. Address *St. Charles, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.