

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **45298**
REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **12441**

FILED JAN 19 1954

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

1. PLACE OF DEATH a. COUNTY 0		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY MO TOWN St. Louis Mo.	
b. CITY (If outside corporate limits, write RURAL and give township) TOWN St. Louis Mo.		c. CITY OR TOWN St. Louis Mo.	
c. LENGTH OF STAY (in this place) 6 Yrs, 0		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Infirmiry Hospital		e. STREET ADDRESS (If rural, give location) 13 5600 Arsenal St	
3. NAME OF DECEASED (Type or Print) a. (First) John		b. (Middle)	
c. (Last) Freeman		4. DATE OF DEATH (Month) (Day) (Year) 12 16 53	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH 6/1/1869
9. AGE (In years last birthday) 84 Yrs		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) Finland		12. CITIZEN OF WHAT COUNTRY? 4	
13a. FATHER'S NAME George, Freeman		13b. MOTHER'S MAIDEN NAME Eva?	
14. NAME OF HUSBAND OR WIFE Eve, Lunder		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME City Infirmiry Records	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Arteriosclerotic Heart Disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis DUE TO (c)	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH years years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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? 4200	
22. I hereby certify that I attended the deceased from 7/1 , 19 51 to 12/16 , 19 53 , that I last saw the deceased alive on 12/16 , 1953, and that death occurred at 10:10 PM from the causes and on the date stated above.			
23a. SIGNATURE George Esker, M.D.		23b. ADDRESS 5600 Arsenal St	
23c. DATE SIGNED Dec 17, 1953		24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	
24b. DATE 1-6-54		24c. NAME OF CEMETERY OR CREMATORY City Crematory	
24d. LOCATION (City, town, or county) (State) St. Louis, Missouri		25. FUNERAL DIRECTOR'S SIGNATURE J. Ryan	
DATE REC'D BY LOCAL JAN 6 1954		ADDRESS 5800 Arsenal St.	

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..

CREMATED BY CITY

Student.....
Signature of Student Embalmer

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