

FILED SEP 6 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27685

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7030

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|---|-----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Missouri</u> | c. LENGTH OF STAY (in this place) | c. CITY OR TOWN <u>St. Louis</u> | 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 <u>St. Louis State Hospital</u> | | e. STREET ADDRESS (If rural, give location) <u>5400 Arsenal Street</u> | |

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| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Bernard</u> | b. (Middle) | c. (Last) <u>Freers</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>8</u> <u>9</u> <u>1955</u> |
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| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u> | 8. DATE OF BIRTH <u>3-22-1891</u> | 9. AGE (In years last birthday) (If under 1 year: Months) (If under 6 mos.: Days) (Hours) (Min.) <u>64</u> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Laborer</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>American Stone</u> | 11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Missouri</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> |
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| 13a. FATHER'S NAME <u>Henry Freers</u> | 13b. MOTHER'S MAIDEN NAME <u>Rose Repetto</u> | 14. NAME OF HUSBAND OR WIFE <u>Stacy Allwort</u> |
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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) <u>Yes</u> <u>W.W.I</u> | 16. SOCIAL SECURITY NO. <u>Unknown</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Thomas M. Brady, Public Administrator</u> | ADDRESS |
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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 <u>6 mos.</u> |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of head of pancreas with metastatic lesions to liver</u> | | |
| | ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> <u>DUE TO (b) Gangrenous scrotum due to metastatic lesion.</u> | | |
| | DUE TO (c) <u>Bronchopneumonia, bilateral, minimal</u> | | <u>4 days</u> |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION <u>159x</u> | 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 9-17, 1951 to 9-55, 1955, that I last saw the deceased alive on 8-9, 1955, and that death occurred at 3:50p. m., from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) <u>A. Hoppe, M.D.</u> | 23b. ADDRESS <u>5400 Arsenal Street</u> | 23c. DATE SIGNED <u>8-10-55</u> |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 24b. DATE <u>8-12-55</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>Jefferson Barracks, Mo.</u> |
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| DATE REC'D BY LOCAL REG. <u>AUG 11 1955</u> | REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe</u> | ADDRESS <u>4700 Washington Blvd</u> |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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..... *G. W. Wilkinson*

Licensed Embalmer No. 35

P. O. Address *M. L. ...*

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.