

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-019691

STATE FILE NUMBER 4950

FILED MAY 16 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

5. 300
1-57

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, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 01 1209 N. Grand			Length of stay in 1b		d. STREET ADDRESS 2119 1209 N. Grand		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Master Shelby T. Freeman III				4. DATE OF DEATH Month Day Year May 7, 1958					
5. SEX Male 2		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> 0 DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 14, 1946		9. AGE (In years last birthday) 11 IF UNDER 1 YEAR Months 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 None		11. BIRTHPLACE (City and state or country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13a. FATHER'S NAME Shelby F. Freeman II			13b. MOTHER'S MAIDEN NAME Frankie Muse			14. NAME OF HUSBAND OR WIFE Child			
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. None		17. INFORMANT Address Frankie Freeman 1209 N. Grand				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>20 days</u>		
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last. } DUE TO (b) _____ DUE TO (c) <u>chronic Hydrocephalus</u>							8 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>3441.</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)						
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.									
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>Sept 1949</u> , to <u>May 7, 1958</u> and last saw <u>her</u> alive on <u>May 7, 1958</u> Death occurred at <u>8:15 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Helmer E. Neuh, M.D.</u> (Degree or title)				22b. ADDRESS <u>4065^a Easton</u>				22c. DATE SIGNED <u>5/8/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 5/10/58		23c. NAME OF CEMETERY OR CREMATORY Washington Park		23d. LOCATION (City, town, or county) Berkley, Missouri			
24. FUNERAL DIRECTOR <u>E. B. Koonce</u> ADDRESS <u>1221 N. Grand</u>				25. DATE RECD. BY LOCAL REG. MAY 9 '58		26. REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Carlene Gibson*

Licensed Embalmer No. *4755*
P. O. Address *122 W. 2nd*

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.