

R. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003398

FILED VS FEB 11 1960

2 1010

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's _____

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	Length of stay in 1b	c. CITY OR TOWN St. Louis	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Enroute City Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) 3970 Juniata
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Robert Middle Wesley Last Freeman			4. DATE OF DEATH Month January Day 27 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/10/1890	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Packer		10b. KIND OF BUSINESS OR INDUSTRY Flour Mill	11. BIRTHPLACE (City and state or country) Morehouse, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.

13a. FATHER'S NAME Unknown Freeman		13b. MOTHER'S MAIDEN NAME Mary Unknown		14. NAME OF HUSBAND OR WIFE Alla May Freeman	
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. 490-18-3180		17. INFORMANT Louise Burrow, 3970 Juniata	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH inst
IMMEDIATE CAUSE (a) Myocardial infarction			
DUE TO (b) Old arteriosclerosis			
DUE TO (c) 420-1			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
---	--	--	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 **Dec 14 53** to **1-27-60** and last saw ^{her}him alive on **12-8-59**
Death occurred at **about 5 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John L. Horner		(Degree or title) M.D.		22b. ADDRESS 114 N. Taylor, St. Louis 8 Mo.		22c. DATE SIGNED 1-28-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1-29-60	23c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery		23d. LOCATION (City, town, or county) St. Louis Co., Mo.		(State)

24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.	ADDRESS	25. DATE RECD. BY LOCAL REG. JAN 28 1960	26. REGISTRAR'S SIGNATURE Loard Smith, M.D.
---	---------	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

19037F

2100.00

2100.00

2000.00

2000.00

1000.00

1000.00

1000.00

1000.00

1000.00

1000.00

1000.00

1000.00

1000.00

1000.00

1000.00

1000.00

1000.00

1000.00

1000.00

1000.00

1000.00

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed (b) or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____ Signature of Student Embalmer

Signed G. W. Wilkins

Licensed Embalmer No. 357

P. O. Address M. L.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.