

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045637

FILED VS. JAN 3 1961

115-116

3020

285

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution/ Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Washington</u>	Length of stay in 1b <u>25 yrs.</u>	c. CITY OR TOWN <u>Washington</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <u>St. Francis Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>625 Stafford St.</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Katherine</u> Last <u>Freese</u>	4. DATE OF DEATH Month <u>Dec.</u> Day <u>29</u> Year <u>1960</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/20/1873</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>9</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Maker</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Washington, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Herman Buddemeyer</u>	13b. MOTHER'S MAIDEN NAME <u>Dorothy Brune</u>	14. NAME OF HUSBAND OR WIFE <u>Charles H. Freese</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>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Charles Buddemeyer, Washington, Mo</u>
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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
IMMEDIATE CAUSE (a)	<u>Arterio-ventricular Heart Block.</u>	<u>11 days.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arterio-sclerotic Heart Disease</u>	<u>6 yrs.</u>
	DUE TO (c) <u>Arterio-sclerosis generalized</u>	<u>10+ yrs.</u>
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 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.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____

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
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21. I attended the deceased from 2/11/66 to 12/29/60 and last saw her alive on 12/29/60
Death occurred at 12:00 Noon m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Michael S. Heppich, M.D.</u>	22b. ADDRESS <u>205 Blue Washington, Mo.</u>	22c. DATE SIGNED <u>12/30/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Dec. 31, 1960</u>	23b. DATE <u>Dec. 31, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Washington, Missouri</u>
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24. FUNERAL DIRECTOR <u>Heppich & Co., Washington, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12/30/60</u>	26. REGISTRAR'S SIGNATURE <u>J. H. Witt</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed

Lester A. Witt

Licensed Embalmer No. 3254

P. O. Address Washington,

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.