

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		c. CITY OR TOWN St. Louis	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hosp		d. STREET ADDRESS (If outside, give location) 6129 Crescent	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Fred Middle W Last Freuning			4. DATE OF DEATH Month Dec Day 21 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/24/1879	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY Board of Education		11. BIRTHPLACE (City and state or country) St. Louis Mo	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Louis Freuning		13b. MOTHER'S MAIDEN NAME Anna Norden		14. NAME OF HUSBAND OR WIFE Ernestine Kahres	

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.	17. INFORMANT Ernestine Freuning 6129 Crescent
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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: IMMEDIATE CAUSE (a) <i>Thrombosis of Left Middle Cerebral Artery</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Dec 14 1960</i>
DUE TO (b) <i>Arteriosclerosis</i>		
DUE TO (c) <i>332+</i>		

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		
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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 <i>March 1946</i> to <i>Dec 21</i> and last saw him alive on <i>Dec 21 1960</i> Death occurred at <i>5:30 P</i> m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <i>Klaus E. Haas</i> (Degree or title) MD	22b. ADDRESS 4909 Lindenwood	22c. DATE SIGNED 12/22/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Dec 24 1960	23c. NAME OF CEMETERY OR CREMATORY Valhalla	23d. LOCATION (City, town, or county) (State) St. Louis City Mo.
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24. FUNERAL DIRECTOR E.J. Schnur 3125 Lafayette	25. DATE RECD. BY LOCAL REG. DEC 22 1960	26. REGISTRAR'S SIGNATURE <i>Karl Smith M.D.</i>
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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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Thomas R. Renu

Licensed Embalmer No. 379

P. O. Address 91250

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