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FILED APR 21 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 8801

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 2211

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Jewish Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Week  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 96

(c) City or town 6345 Clayton Ave.  
(If outside city or town limits, write "RURAL")

(d) Street No. 6345 Clayton Ave.  
(If rural, give location)

(e) If foreign born, how long in U. S. A. 1 years.

3. (a) PRINT FULL NAME Louis L. Freund

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. 497-03-9282

20. DATE OF DEATH: Month March day 9 year 1941 hour 11 minute 55 A. M.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Bella

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased July 31 1875  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 1 1941, to March 9 1941; that I last saw him alive on 3/9 1941; and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>7</u>	<u>8</u>	hr. _____ min. _____

Immediate cause of death Carcinoma of sigmoid colon.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Secretary--Treasurer

11. Industry or business Waldheim Platt & Co.

Other conditions H69  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

MOTHER FATHER

12. Name Bernard Freund

13. Birthplace Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Julie Epstein

15. Birthplace Germany  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. HERRIETTA ROTH

(b) Address 6345 CLAYTON AVE

17. (a) Burial (b) Date thereof Mar. 11-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Sinai Cemetery

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

18. (a) Signature of funeral director Herman Findey

(b) Address 5216 Delmar Blvd.

19. (a) MAR 10 1941 (b) J. Medrek  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_  
(Specify type of place) (c) Means of injury

23. Signature Alfred Waldheim (M. D. or other) MD

Address 6345 Clayton Ave Date signed 3/11/41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed.....

*Chas. W. Cooper*

Licensed Embalmer No. ....

*3830*

P. O. Address.....

*5216 Dulman*

**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 this body is not embalmed, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 88017

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 2211

1. PLACE OF DEATH

(a) County St Louis  
(b) City or town St Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Louis L. Freund  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
65 7 8 hr. min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 7-29-41 (b) J. J. Bredeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Louis  
(c) City or town St Louis Clayton Ave N.P.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6345 Clayton Ave  
(If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH Month mar day 9  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature Alfred Weidman (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

