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7-39
K21492

FILED AUG 28 1941 79
Registration District No. _____

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **City Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 month**
In this community **10 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **2410 S. 3rd St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **Freeborg, Carl**

3. (b) If veteran, name war _____
3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widower**

6. (b) Name of husband or wife **Ida**
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **August ? 1866**
(Month) (Day) (Year)

8. AGE: Years **74** Months **11** Days **?**
If less than one day hr. _____ min.

9. Birthplace **Unknown** **Sweden**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business _____

MOTHER FATHER { 12. Name **Unknown**
18. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Carl E. Freeborg**
(b) Address **2410 S. 3rd St.**

17. (a) **Burial** (b) Date thereof **7/7/41**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Riverside Cem. Moline, Ill.**

18. (a) Signature of funeral director **Wacker-Heldnerle**
(b) Address **3634 Gravois Ave**

19. (a) **JUL 5 1941** (b) **R. J. Maxwell**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **4**
year **1941** hour **7:45** minute **A** 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 _____

Chronic Nephritis

Due to _____

Due to _____

Other conditions **General Arterio-sclerosis**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **A; Above**

Duration

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 **R. J. Maxwell** (M. D. or other) _____
Address _____ Date signed _____

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

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 Robert Wheeler

Licensed Embalmer No. 2128

P. O. Address St. Louis, Mo.

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, above space should be left blank.