

S. No. 2
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v. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUL 7 1947

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6150**

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:
Deaconess Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **6 weeks**
 In this community **Life**
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
 (c) City or town **Florissant**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **15 Spring Drive**
N.R. (If rural, give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME **Theodore Freise**
 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 **Married**
 6. (b) Name of husband or wife **Emma Jacobs Freise**
 6. (c) Age of husband or wife if alive **60** years
 7. Birth date of deceased **1886 Jan. 26**
 (Month) (Day) (Year)

8. AGE: Years **61** Months **5** Days **2**
 If less than one day hr. min.

9. Birthplace **St. Louis Missouri**
 (City, town, or county) (State or foreign country)
 10. Usual occupation **Custodian of Schools**

11. Industry or business **---**
 12. Name **Theodore G. Freise**
 13. Birthplace **Germany**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Dora Reckamp**
 15. Birthplace **St. Louis Missouri**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Emma Freise**
 (b) Address **Florissant, Mo.**

17. (a) **Burial** (b) Date thereof **6/28/47**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Valhalla Cemetery**

18. (a) Signature of funeral director **White Funeral Home**
 (b) Address **Ferguson, Missouri**

19. (a) **JUN 27 1947** (b) *[Signature]*
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **26**
 year **1947** hour **7** minute **P.** M.

21. I hereby certify that I attended the deceased from **13 Feb.**
 19**47** to **26 June** 19**47**
 that I last saw him alive on **26 June** 19**47**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Metastatic Carcinoma**
Primary Bladder carcinoma
metastatic to lungs and
Due to local extension to pelvic &
extrapelvic regions, left side
 Duration **3 years**
 Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death) **52**

Major findings:
 Of operations.....
 Of autopsy.....
 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 **John R. Schwartman** (M. D. or other) **MD**
 Address **204 Humboldt Bldg.** Date signed **6-27-47**

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

MOTHER FATHER

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 *L. M. White*.....

Licensed Embalmer No. *3973*.....

P. O. Address *Hergman, 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, fact should be so stated above.