

No. 2
-12-45
-17-39
K47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35730**
Registrar's No. **9852**

FILED NOV 7 1947 **318**
Registration District No.

Primary Registration District No. **1003**

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

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:
Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)

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

In this community.....
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Charles P. Freesmeier

3. (b) If veteran, name war..... No

3. (c) Social Security No..... None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife..... Anna Huelmann

6. (c) Age of husband or wife if alive..... 76 years

7. Birth date of deceased October 1, 1871
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>76</u>	<u>0</u>	<u>21</u>	hr. min.

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

10. Usual occupation Glazier Retired

11. Industry or business.....

12. Name John Freesmeier

13. Birthplace Germany
(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 Frank Freesmeier

(b) Address 4550 Durant

17. (a) Burial (b) Date thereof Oct. 25 '47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery
Bromschwig and Son Funeral Home

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

(b) Address 4746 W. Florissant Ave.

19. (a) OCT 24 1947 (b) J. F. Brock
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 200

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4550 Durant
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 22
year 1947 hour 11 minute A.M.

21. I hereby certify that I attended the deceased from Sept 25
1947 to death, 19.....
that I last saw him alive on Oct 22, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Cardiac decompensation

Due to strain

Due to mental confusion, restlessness

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

Major findings:
Of operations.....

Of autopsy.....

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 T. J. Brock (M. D. or other) P

Address University Club Bldg Date signed 10/24/47

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.....

W. Wilkinson

Licensed Embalmer No.....

3575

P. O. Address.....

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.