

FILED DEC 16 1950

STANDARD CERTIFICATE OF DEATH

State File No. 22252
9187

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE Missouri b. COUNTY St. Louis Co.			
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 3 wks		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis Co. Mo. 4181		d. STREET ADDRESS (If rural, give location) 1538 Ferguson Ave	
d. FULL NAME OF HOSPITAL OR INSTITUTION Park Lane Hosp				3. NAME OF DECEASED a. (First) _____ b. (Middle) Elise c. (Last) Freese			
4. DATE OF DEATH (Month) (Day) (Year) 10-29-50		5. SEX F		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH July 3, 1875		9. AGE (In years last birthday) 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Newedde Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Wilhelm Strunk		13b. MOTHER'S MAIDEN NAME Anna Marie Stackhorne		14. NAME OF HUSBAND OR WIFE John W. Freese	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME John W. Freese		ADDRESS 1538 N Ferguson Ave	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sarcoma Left Ovary INTERVAL BETWEEN ONSET AND DEATH _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION Sarcoma Left Ovarian Tumor				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 175X					
22. I hereby certify that I attended the deceased from Oct 1, 1950 , to Oct 29, 1950 , that I last saw the deceased alive on Oct 29, 1950 , and that death occurred at 12:08 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE J. H. Walter MD (Degree or title)				23b. ADDRESS 536 N Poyler		23c. DATE SIGNED 10-30-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Nov 1, 1950		24c. NAME OF CEMETERY OR CREMATORY Zion Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.	
DATE REC'D BY LOCAL REG. OCT 30 1950		REGISTRAR'S SIGNATURE J. B. Fasano		25. FUNERAL DIRECTOR'S SIGNATURE Alexander & Sons ADDRESS 6175 Pelmar			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Joe E McCulloch

Signed.....
Student Embalmer

Licensed Embalmer No. *2460*

P. O. Address *6175 Redman*

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.