

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 4 1954

318

1003

State File No. 1232
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE Missouri b. COUNTY Gasconade	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN Hermann	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		e. STREET ADDRESS (If rural, give location) 106 W 2nd St 0371	

3. NAME OF DECEASED (Type or Print) a. (First) MARIE b. (Middle) A. c. (Last) FREULER			4. DATE OF DEATH (Month) (Day) (Year) February 6, 1954		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jul 4. 1883	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Hermann Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Christ Schlender	13b. MOTHER'S MAIDEN NAME Mary Oelschlaeger	14. NAME OF HUSBAND OR WIFE Louis Freuler
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME W.C. Schlender	ADDRESS Hermann Mo
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of stomach with metastases		
	II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		
ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 151X

22. I hereby certify that I attended the deceased from **Dec. 19, 1953**, to **Feb. 6, 1954**, that I last saw the deceased alive on **Feb. 6, 1954**, and that death occurred at **9:10 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE J. C. Smith Jr.	(Degree or title) M. D.	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 2/6/54
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24a. BURIAL, CREMATION, REMOVAL Removal	24b. DATE 2-7-54	24c. NAME OF CEMETERY OR CREMATORY City	24d. LOCATION (City, town, or county) (State) Hermann Mo
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DATE REC'D BY LOCAL REG FEB 8 1954	REGISTRAR'S SIGNATURE J. C. Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

000-8-1030
1954

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 Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Robert B. Murray*.....
Licensed Embalmer No. 99

P. O. Address *St. Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.