

FILED AUG 9 - 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **24117**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **310** PRIMARY REG. DIST. NO. **3058** Registrar's No. **165**

1. PLACE OF DEATH a. COUNTY <b>St. Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Charles</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Charles</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Charles</b>	
c. LENGTH OF STAY (in this place) <b>3 weeks</b>		d. STREET ADDRESS (If rural, give location) <b>8th. &amp; Clay St.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph Hospital</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Martha</b>	b. (Middle) <b>Ann</b>	c. (Last) <b>Freymuth</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>July 29, 1954</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. <del>MARRIED</del> , NEVER MARRIED, <input checked="" type="checkbox"/> WIDOWED, DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 6 1865</b>	9. AGE (In years last birthday) <b>89</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>House work</b>	11. BIRTHPLACE (State or foreign country) <b>Josephville Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Adolph Freymuth</b>	13b. MOTHER'S MAIDEN NAME <b>Brass</b>	14. NAME OF HUSBAND OR WIFE _____
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>nono</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Stella Freymuth</b> ADDRESS <b>O'Fallon Mo.</b>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Uremia</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cerebral Hemorrhage</b> DUE TO (c) <b>Arteriosclerosis</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Seizure</b>		?	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>331X</b>	20. AUTOPSY? YES <input 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **May 22, 1954**, to **July 29, 1954**, that I last saw the deceased alive on **July 27, 1954**, and that death occurred at **9A** m., from the causes and on the date stated above.

23a. SIGNATURE <b>[Signature]</b> (Degree or title) <b>M.D.</b>	23b. ADDRESS <b>St Charles Mo</b>	23c. DATE SIGNED <b>July 31-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>July 31-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Assumption</b>	24d. LOCATION (City, town, or county) (State) <b>O'Fallon Mo.</b>
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DATE REC'D BY LOCAL REG <b>Aug 3 1954</b>	REGISTRAR'S SIGNATURE <b>Samuel Hamilton</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>E. Keethy</b> ADDRESS <b>O'Fallon Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

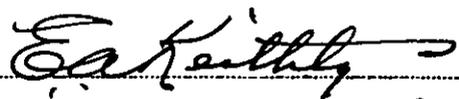
STATEMENT BY LICENSED EMBALMER

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.....



Signed.....

Student Embalmer

Licensed Embalmer No. 822

P. O. Address O'Fallon Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.