

Health,
Welfare
Public
Service

300
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

FILED OCT 14 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33511

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 8651

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Clay	
b. CITY: (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN Flora	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 714 E. 4th. St.	
3. NAME OF DECEASED (Type or print) First THOMAS Middle JEFFERSON Last FREEMAN		4. DATE OF DEATH Month SEPT. Day 14, Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman - Watkins Products		11. BIRTHPLACE (City and state or country) Missouri	
13a. FATHER'S NAME John Freeman		14. NAME OF HUSBAND OR WIFE Eunice Freeman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT 1816 E. 56th. St. Henry Freeman - E. St. Louis, Illinois	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ABDOMINAL CARCINOMATOSIS (Biliary Tract - Primary Site ?) DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Few Mos.
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY . Hour Month, Day, Year o.m. p.m.		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from SEPT. 10, 1957 to SEPT. 14, 1957 and last saw her/him alive on SEPT. 14, 1957 Death occurred at 2:08 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE C. Vermillion, M.D. (Degree or title)		22b. ADDRESS BARNES HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL Removal		23d. LOCATION (City, town, or county) (State) East St. Louis, Illinois	
24. FUNERAL DIRECTOR Joseph J. Kassy		25. DATE RECD. BY LOCAL REG. SEP 16-57	
23b. DATE 9-14-57		23c. NAME OF CEMETERY OR CREMATORY	
23e. ADDRESS East St. Louis, Ill.		26. REGISTRAR'S SIGNATURE J. Carl Smith MD	

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

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 Not Embalmed, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Joseph J. Kessly

Licensed Embalmer No. 7541
P. O. Address St. Louis

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.