

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034624

FILED VS. SEP 28 1959 317

Primary Registration District No. 543

Registrar's No. 2531

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>St. Louis Co.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Jennings Mo.</b>		Length of stay in 1b <b>MONS.</b>		c. CITY OR TOWN <b>Jennings</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>High Towers Nursing Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2520 McLaren Ave</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>LULA B. Frees</b>				4. DATE OF DEATH Month <b>9</b> Day <b>22</b> Year <b>59</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>W.</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>May (?)</b>	9. AGE (last birthday) <b>About 78 Yrs</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Social Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Chotar Landing Miss</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Gabe Brown</b>			13b. MOTHER'S MAIDEN NAME <b>Bertha Bloom</b>		14. NAME OF HUSBAND OR WIFE <b>Ben R. Frees (Deceased)</b>		
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>499-34-6457a</b>	17. INFORMANT Address <b>Ralph Kalish 721 Olive St</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Cerebral vascul disease</b> DUE TO (c) <b>unknown</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>convulsive disorder</b> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 a.m. p.m.	Month, Day, Year						
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.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <b>April 25, 1956</b> to <b>Sept 22, 1959</b> and last saw her <sup>him</sup> alive on <b>Sept 22, 1959</b> Death occurred at <b>11A</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Lewis Littmann M.D.</b>				22b. ADDRESS <b>8231 Clayton Rd (17)</b>		22c. DATE SIGNED <b>9-22-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/23/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla</b>		23d. LOCATION (City, town, or county) <b>7600 St. Charles</b>		(State)
24. FUNERAL DIRECTOR <b>Mayer 4356 Lindell Blvd</b>				25. DATE RECD. BY LOCAL REG. <b>9-23-59</b>		26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
~~or by~~ \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Lawrence O. Healy

Licensed Embalmer No. 4979

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.