

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

-61-034317

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

Primary Registration District No. 1003

Registrar's No. 8680

STATE FILE NUMBER

AMENDED

Registration District No.

FILED SEP 27 1961

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis			Length of stay in 1b		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Enroute City Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3624 McRoe Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Eugene Vincent Freehill				4. DATE OF DEATH Month Day Year September 16, 1961			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 1/22/1935	9. AGE (last birthday) 26	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10b. KIND OF BUSINESS OR INDUSTRY Medical School		11. BIRTHPLACE (City and state or country) Urbana, Ill.	12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME Vincent J. Freehill			13b. MOTHER'S MAIDEN NAME Kathleen Hudson		14. NAME OF HUSBAND OR WIFE Margery J. Freehill		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No					17. INFORMANT Address Margery J. Freehill, 3624 McRoe Ave.		
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE Ruptured Thoracic Aorta; Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>ruptured when car operated by deceased went out of control and struck girder on MacArthur bridge, about 24^{1/2} p.m. September 16th, 1961.</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a)						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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <i>See above</i>					
20c. TIME OF INJURY Hour Month, Day, Year 24 ^{1/2} p.m. 9-16-61			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Bridge</i>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <i>St. Louis, Mo</i>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Joseph M. Freeman, M.D.</i>				22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>9-18-61</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>9-19-61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Josephs Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Peoria, Ill.</i>			
24. FUNERAL DIRECTOR ADDRESS <i>Albert H. Hoppe, Inc., 4700 Washington Blvd.</i>			25. DATE RECD. BY LOCAL REG. <i>SEP 18 1961</i>		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>		

RATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

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 me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Robert M. Murray

Licensed Embalmer No. 2749

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.