

MAY 2 1929

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County Saline Registration District No. 796
Township Marshall Primary Registration District No. 3038
City Marshall Mo (No.) St. Ward)

File No. 13433
Registered No. 50

2. FULL NAME

Clark Freeland

(a) Residence No. St. Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>blk</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>1879</u>		
7. AGE YEARS	MONTHS	DAYS
<u>abt 50</u>		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Labor</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) <u>mo</u> (STATE OR COUNTRY)		
10. NAME OF FATHER <u>Charles Freeland</u>		
11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Virginia</u> (STATE OR COUNTRY)		
12. MAIDEN NAME OF MOTHER <u>Patsy Hutchins</u>		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Virginia</u> (STATE OR COUNTRY)		
14. INFORMANT <u>Lehan Freeland</u> (Address)		
15. FILED <u>3-10-29</u> Mrs. John H. McGuire REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 2, 1929

17. I HEREBY CERTIFY, That I attended deceased from March 1st, 1929, to March 2, 1929 that I last saw deceased alive on March 2, 1929 and that death occurred, on the date stated above, at 1:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumo-Pneumonia
1074

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY) 100%
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Marshall, Mo

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Physical Exam
(Signed) W. H. Madison, M. D.

3/4, 1929 (Address) Marshall, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Fairview Cem DATE OF BURIAL Mar 4 1929

20. UNDERTAKER L. R. Vandiner ADDRESS Marshall Mo

COPY TO FILE WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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