

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

Do not use this space.

33438

1. PLACE OF DEATH

County Franklin
Township _____
City Washington (No. _____)

Registration District No. 297
Primary Registration District No. 2016

File No. _____
Registered No. 48
St. _____ Ward _____

2. FULL NAME

Lillian Marie Freie

(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. 14 ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Henry Freie

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-19-1892

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>36</u>	<u>11</u>	<u>27</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Geo. W. Warner

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Mary Bopp

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Missouri

14. INFORMANT Clara E. Stephens
(Address) Pacific Mo

15. FILED Oct 17 1929 E. L. Munn REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct-16, 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct-2 1929 to Oct-16 1929, that I last saw her alive on Oct-15 1929, and that death occurred, on the date stated above, at 1:40 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Volvulus (ascending colon)

11801 (duration) 36 yrs. 14 mos. 4 ds.

CONTRIBUTORY (SECONDARY) General Sepsis (Absorption Toxic products from alimentary canal) (duration) _____ yrs. _____ mos. 5 ds.

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

DID AN OPERATION PRECEDE DEATH? yes DATE OF 10-11-1929

WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS clinical

(Signed) E. E. Mankoff M.D.
10/16, 1929 (Address) Washington 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 Pacific City Cemetery DATE OF BURIAL 10/18 1929

20. UNDERTAKER Geo. A. Puchner ADDRESS Pacific Mo

WHITE PLAINLY, 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 the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

