

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

24 1930

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

Do not use this space.

15615

1. PLACE OF DEATH

County Jackson Clay
Township Low Calvin
City Kansas City Gasland Mo.

Registration District No. 197
Primary Registration District No. 5276
Gasland, Missouri

File No. _____
Registered No. 287
St. _____ Ward _____

2. FULL NAME Emma B. Freeman

(a) Residence. No. Gasland Mo St. _____ Ward. Gasland, Mo.
(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (widow the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Frank A. Freeman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 6, 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
60 2 7

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) Kansas

10. NAME OF FATHER Alex Fisher

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

12. MAIDEN NAME OF MOTHER Elizabeth Yearion

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

14. INFORMANT Mr. T. W. Wood (Address) Gasland Mo.

15. FILED 5/14 1930 JRW aqg REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 13, 1930

17. I HEREBY CERTIFY, That I attended deceased from May 13, 1930, to May 13, 1930 that I last saw him alive on May 13, 1930, and that death occurred, on the date stated above, at 11 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Paralysis Total

8 d (duration) yrs. 5 mos. ds.

CONTRIBUTORY (SECONDARY) 75 B (duration) yrs. _____ mos. _____ ds.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____ WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical symptoms (Signed) J. P. Potts, M. D. 5/13 1930 (Address) Gasland 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 Elmwood Cem DATE OF BURIAL 5-15-1930

20. UNDERTAKER Shaw + Mc Cleere ADDRESS 3235 Clay

