

NOV 21 1930

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

Do not use this space.

32118

1. PLACE OF DEATH  
 County Ruchanan Registration District No. 85  
 Township St. Joseph Mo Primary Registration District No. 1001  
 City St. Joseph Mo (No. State Hospital #2.) St.                      Ward                     

2. FULL NAME Jerry Freeman  
 (a) Residence No. St. Joseph Mo 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.

File No.                       
 Registered No. 1093  
 St.                      Ward                     

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) About 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
70 | - | -

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

9. BIRTHPLACE (CITY OR TOWN) Unknown  
 (STATE OR COUNTRY) Unknown

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT (Address) State Hospital Records  
St. Joseph Mo

15. FILED 3 1930  
John G. [Signature]  
 REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 3 1930

I HEREBY CERTIFY, That I attended deceased from Nov 30 1929 to Oct 3 1930  
 that I last saw him alive on Oct 25 1930 and that death occurred, on the date stated above, at 5:25 a m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Cerebral Arteriosclerosis  
97

(duration) ..... yrs. .... mos. .... ds.

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

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

19. DID AN OPERATION PRECEDE DEATH..... DATE OF.....

20. WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS                       
 (Signed) D. G. Miles, M. D.  
Oct 3, 1930 (Address) St. Joseph 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 Lexington, Missouri DATE OF BURIAL Oct, 4, 1930

20. UNDERTAKER Walter Treichel ADDRESS 1302 Faron St.

N. E.—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.

