

REC'D DEC 13 1938

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

38673  
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85  
 (b) Township St. Joseph Primary Registration District No. 1001 Registered No. 1183  
 (c) City St. Joseph (d) Street No. 318 S. 16th St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Francis Free

(a) Residence, No. 318 S. 16th St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) Single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9/13/'68.  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
70 2 12  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housework  
 9. Industry or business in which work was done, as saw mill, bank, etc. Private Family  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) Savannah  
 (STATE OR COUNTRY) Missouri 0

FATHER 13. NAME Unknown  
 14. BIRTHPLACE (CITY OR TOWN) Unknown 9  
 (STATE OR COUNTRY) Unknown

MOTHER 15. MAIDEN NAME Unknown  
 16. BIRTHPLACE (CITY OR TOWN) Unknown 9  
 (STATE OR COUNTRY) Unknown

17. INFORMANT Pearl Phelps  
 (ADDRESS) 318 S. 16th, St.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Mora, Cem, DATE 11/30/'38

19. FUNERAL DIRECTOR Graves Funeral Home.  
 (ADDRESS) 806 S. 17th, St.

20. FILED 11-30 1938 W. J. Hittorich  
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 25, 1938  
 22. I HEREBY CERTIFY, That I attended deceased from November 24, 1938 to November 25, 1938  
 I last saw her alive on Nov 24, 1938. Death is said to have occurred on the date stated above, at 12:20 P.M.  
 The principal cause of death and related causes of importance were as follows:

Paralysis General Date of onset \_\_\_\_\_  
Old age

Other contributory causes of importance: Old age  
 Name of operation None Date \_\_\_\_\_  
 What test confirmed diagnosis? Obviant Was there an aneurysm? No

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? No Date of injury No, 19\_\_\_\_  
 Where did injury occur? None  
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. Died 318 S 16  
 Manner of injury None  
 Nature of injury None

24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify None  
 (Signed) W. J. Hittorich, M. D.  
 (Address) 720 S 2 1/2 St Joseph Mo

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

11  
5  
7

1 X1204

STATEMENT BY LICENSED EMBALMER

I, A. T. Moore, Licensed Embalmer No. 948

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Me

L. E.

No. 948 or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed

*A. T. Moore*

Licensed Embalmer No. 948

**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.)**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85  
(b) Township \_\_\_\_\_ Primary Registration District No. 1001 Registered No. \_\_\_\_\_  
(c) City St Joseph (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yr. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Francis Free

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Single the word)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
70 2 12

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED \_\_\_\_\_ 19\_\_\_\_ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 25, 1938

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_  
I last saw h. alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
The principal cause of death and related causes of importance were as follows:

paralytic general cerebral hemorrhage  
Date of onset \_\_\_\_\_  
Other contributory causes of importance: edema of 2nd

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) J. B. Crowland, M. D.  
(Address) St Joseph, Mo.

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
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.

