

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.

JAN 11 1940

State File No. _____

Registration District No. 486

Primary Registration District No. 4293

Registrar's No. 39

1. PLACE OF DEATH:
 (a) County Lincoln
 (b) City or town Elsberry Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 45 years years, months or days

3. (a) PRINT FULL NAME George B. Freels 642
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced, married
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased June 20 1870
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 5 27 hr. _____ min.

9. Birthplace Pike Co Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation Car Mechanic

11. Industry or business _____
 12. Name John Freels
 13. Birthplace Pike Co Mo
 (City, town, or county) (State or foreign country)
 14. Maiden name Elizabeth Allen
 15. Birthplace Pike Co Mo
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mr G.B. Freels
 (b) Address Elsberry Mo

17. (a) Burial (b) Date thereof 12-19-39
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Elsberry Cemetery

18. (a) Signature of funeral director W.H. Bradley
 (b) Address Elsberry Mo

19. (a) Dec. 19-39 (b) Eda Powell
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Lincoln
 (c) City or town Rural Elsberry
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec, 17th, 39 day
 year _____ hour 9 P. M.
 21. I hereby certify that I attended the deceased from 31 Dec, 17th, 39 to 31 Dec, 17th, 39
 that I last saw him alive on Dec 17th and that death occurred on the date and hour stated above.

Immediate cause of death
Heart failure due to
absorption of poison from
abscess Liver
Abscess Liver, or G.B.
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Duration

Major findings:
 Of operations Operated in Nov, 1939
 Of autopsy None

PHYSICIAN

 Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (a) Means of injury _____
 23. Signature G.V. Keeling (M. D. or other) _____
 Address Elsberry, Mo. Date signed 12-19-39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No. *3966*

P. O. Address..... *Edmund M*

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.)

If this body is not embalmed, above space should be left blank.