15793

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 678 Primary Registration District No. 5904 Registrar's No.

1. PLACE OF DEATH:

(a) County Phelps, County. Tyler

(b) City or town St James, Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St James Hospital. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution five days. (Specify whether
In this community St James, Mo.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County Phelps

(c) City or town St James,
(If outside city or town limits, write "RURAL")

(d) Street No. X
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Albert Porter Freeman. 655

3. (b) If veteran, name war No

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 Ernie Freeman.

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Oct, 2nd 1863
(Month) (Day) (Year)

8. AGE: Years 76 Months 6 Days 22 If less than one day hr. min.

9. Birthplace St James, Missouri.
(City, town, or county) (State or foreign country)

10. Usual occupation Painter & Paperhanger

11. Industry or business 9

FATHER
12. Name Not Known. 1
13. Birthplace " 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name " 1
15. Birthplace " 1
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature L. W. Freeman
(b) Address 2806 Missouri Ave. St Louis, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation Masonic Cem. St Jos. Mo.

18. (a) Signature of funeral director Jonas & Gorman
(b) Address St James, Missouri.

19. (a) 5-1-1940 (Date received local registrar) (b) Elsie B. Houk (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 24 - 1940
year 1940 hour 4 30 minute 8 M.

21. I hereby certify that I attended the deceased from 4/21 - 1940, to 4-24, 1940
that I last saw him alive on 4/24, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Uremia	
Due to Carcinoma of Prostate gland	
Due to Ch. Inflammation & Dilatation	
Other conditions ✓ (Include pregnancy within 3 months of death)	
Major findings: Of operations no	
Of autopsy no	

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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) no
(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? ✓ (Specify type of place)
While at work? ✓ (e) Means of injury ✓

23. Signature E. A. Scott (M. D. or other) 1
Address St James Hospital St James Mo Date signed 4/25/40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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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.....

RECEIVED....., Registered Apprentice No.....

working under my personal supervision.

District Health Officer No. 9

District File Number 540 562

Date Filed 57040

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.