

FILED SEP 24 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

30051

Registration District No. 908

Primary Registration District No. 6223

State File No.

Registrar's No. 40

1. PLACE OF DEATH:

(a) County Wright  
(b) City or town Dawson  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution

(Specify whether

In this community  
years, months or days)

8. (a) PRINT FULL NAME John Wesley Freels

3. (b) If veteran,  
name war

3. (c) Social Security  
No.

4. Sex M

5. Color or  
race W

6. (a) Single, widowed, married,  
divorced m

6. (b) Name of husband or wife Mary

(c) Age of husband or wife if  
alive \_\_\_\_\_ years

7. Birth date of deceased

Oct 30 1858  
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

81

9

11

hr.

min.

9. Birthplace

Missouri  
(City, town, or county)

(State or foreign country)

10. Usual occupation

Farmer (Retired)

11. Industry or business

12. Name

Charles Freels

13. Birthplace

Missouri  
(City, town, or county)

(State or foreign country)

14. Maiden name

Arkerson

15. Birthplace

Arkerson  
(City, town, or county)

(State or foreign country)

16. (a) Informant

John Freels

(b) Address

Dawson, Mo

17. (a) (Hospital, cremation, or removal)

Funeral Home

(b) Date thereof

Aug 11 1940  
(Month) (Day) (Year)

(c) Place: burial or cremation

Funeral Home

18. (a) Signature of funeral director

[Signature]

(b) Address

[Address]

19. (a) 8-14-40  
(Date received local registrar)

(b) [Signature]  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Wright

(c) City or town Dawson  
(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 Aug day 11  
year 1940 hour 7 minute P. M.

21. I hereby certify that I attended the deceased from  
Aug 6, 1940, to Aug 11, 1940  
that I last saw him alive on Aug 10, 1940,  
and that death occurred on the date and hour stated above.

Immediate cause of death

arteriosclerosis

Due to

Due to

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations

Of autopsy

Duration

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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?

(e) (Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address [Address] Date signed 8-12-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

-10-39  
17-39  
X21492

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RECEIVED

District Health Officer No. 6,

District File Number 440-2621

Date Filed ~~SEP 17 1940~~ SEP 18 1940

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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 \_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

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