

JAN 25 1940

Registration District No. 677

Primary Registration District No. 4403-5901

Registrar's No. 139

81

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

1. PLACE OF DEATH:

(a) County Phelps
 (b) City or town Rolla
 (c) Name of hospital or institution: Home of Aunt Mrs K.M. LENOX
 (d) Length of stay: In hospital or institution. (Specify whether in this community years, months or days) 2

3. (a) PRINT FULL NAME Amanda F. Freeman

3. (b) If veteran, name war 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) ~~Single~~ Married, divorced

6. (b) Name of husband or wife Wm Freeman 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 14 1855
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	85	1	3	_____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Bagley

13. Birthplace Mo
 (City, town, or county) (State or foreign country)

14. Maiden name Margaret Cochrane

15. Birthplace Mo
 (City, town, or county) (State or foreign country)

16. (a) Informant Ken Lohr

(b) Address Rolla Mo

17. (a) LAKE SPRING (b) Date thereof Nov 17 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LAKE SPRING, Mo

18. (a) Signature of funeral director Thos F. Son

(b) Address Rolla Mo

19. (a) Nov. 17, 1940 (b) Joe F. Myers
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps
 (c) City or town Rolla Hobson STAR
 (d) Street No. New Lake Johnson
 (e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 16
 year 1940 hour 4:00 minute 17 M.

21. I hereby certify that I attended the deceased from 9:21,
1940 to Nov 16, 1940
 that I last saw her alive on Nov 10, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death: Senility
 Due to: _____
 Due to: _____

Other conditions Ch. myocarditis
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations: _____
 Of autopsy: _____

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? _____
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
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While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature E.E. Fain M.D. (M. D. or other) _____
 Address Rolla Date signed 11-17-40

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

RECEIVED
District Health Officer No. 5,
District File Number 12401223
Date Filed _____

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 with the above constitutes grounds for revocation of license.)

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