

FILED JUN 17 1943

Registration District No. 1121

Primary Registration District No. 4186

Registrar's No. 18

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

046

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Sullivan, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: North Side Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Weeks
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs. Eclair Freese

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife C.E. Freese

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

7. Birth date of deceased Feb. 26th. 1890
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>53</u>	<u>2</u>	<u>28</u>	hr. min.

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

10. Usual occupation At Home

11. Industry or business House Wife

12. Name Frank Smith,

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

14. Maiden name Amanda Outland,

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

16. (a) Informant C.E. Freese

(b) Address Potosi, Mo.

17. (a) Cremation (b) Date thereof May 27, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla, St. Louis, Mo.

18. (a) Signature of funeral director J. Williams

(b) Address Sullivan, Mo.

19. (a) 5/26/43 (b) J. Williams
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Franklin

(c) City or town Sullivan, Mo.
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 24th.
year 1943 hour 6 minute 1st. A.M.

21. I hereby certify that I attended the deceased from 1943, 19____, to May 24th., 19____.

that I last saw h_____ or alive on May 24th., 19____, at 6 A.M., 19____.

and that death occurred on the date and hour stated above.

Immediate cause of death Endocarditis

Due to Chronic Arthritis

Other conditions Cancer Of the Uterus
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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) (e) Means of injury _____

23. Signature James R. Howard (M. D. or other) _____
Address North Side Hospital, Sullivan, Mo. Date signed _____

1121

JUN 17 1944

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.....

J. T. Williams

..... Licensed Embalmer No. 427.....

..... P. O. Address Sullivan, Mo......

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, fact should be so stated above.

Registration District No. 114 Primary Registration District No. 4186

1. PLACE OF DEATH:
(a) County Franklin
(b) City or town Sullivan
(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)

3. (a) PRINTED FULL NAME E. Georgia Claire Flease
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb 26 (Month) (Day) (Year)

8. AGE: Years 53 Months 2 Days _____ If less than one day _____ min. _____
9. Birthplace Ohio (City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business _____
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____
19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ year 1943 hour _____ minute _____ M. _____
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him/her alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

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 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 poison) (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER, FATHER

S-21272