

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28619

State File No.

Registrar's No. 137

Registration District No. 383

Primary Registration District No. 5653

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Mount Vernon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri State Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 487 days
(Specify whether
In this community 487 days
years, months or days)

3. (a) PRINT FULL NAME ORA FREEMAN

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex male 5. Color or race Colored 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased April 29 1910
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
33 3 14 hr. min.

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

10. Usual occupation Farmer

11. Industry or business X

12. Name Jack Freeman

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

14. Maiden name Ella Harriet Pyleson

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

16. (a) Informant Mr. Michael Reed Clerk

(b) Address Mo State San, Mt Vernon Mo

17. (a) Removal (b) Date thereof Aug 13-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Windsor Mo

18. (a) Signature of funeral director Geo B Orr

(b) Address Mt Vernon Mo

19. (a) 8/12/43 (b) Acely Crowder
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry
(c) City or town Calhoun
(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 Aug day 12
year 1943 hour 8 minute 20 A.M.

21. I hereby certify that I attended the deceased from April 12 1942 to Aug 11 1943
that I last saw him alive on Aug 11 1943
and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary tuberculosis

Due to _____
Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy Pulmonary tuberculosis

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) _____ (Means of injury)

23. Signature [Signature] (M. D. or other) _____
Address State Registrar Date signed 8-12-43

Duration over 2 yrs.

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

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

MOTHER FATHER

1337

(Licensed Embalmer's Statement on Reverse Side)

(Dr. A.M. Hinklepleck)

RECEIVED

District Health Officer No. 6,

District File Number 843-958

Date Filed AUG 25 1943

SEP 7 1943

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 George B Orr
Licensed Embalmer No. 946
P. O. Address Mt Vernon W

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.