

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

FILED JAN 6 1944

43582

1. PLACE OF DEATH

County St. Francois

Registration District No. 316

Township St. Francois

Primary Registration District No. 6075

City Farmington

(No. 2, State Hospital No. 4)

File No.

Registered No. 367

2. FULL NAME CAROLINE FREEMAN

(a) Residence, No. St. St. Louis, Missouri Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Max Freeman

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 10, 1867

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>76</u>	<u>6</u>	<u>24</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) Unknown

11. Total time (years) spent in this occupation Unknown

12. BIRTHPLACE (CITY OR TOWN) Farmington
(STATE OR COUNTRY) Missouri

FATHER 13. NAME Green Thurmen

14. BIRTHPLACE (CITY OR TOWN) Ste. Genevieve Co.,
(STATE OR COUNTRY) Missouri

MOTHER 15. MAIDEN NAME Caroline VanSickle

16. BIRTHPLACE (CITY OR TOWN) Ste. Genevieve Co.,
(STATE OR COUNTRY) Missouri

17. INFORMANT Records State Hospital No. 4
(ADDRESS) Farmington, Missouri

18. BURIAL, CREMATION, OR REMOVAL
PLACE Parkview Cem., DATE Dec. 8, 1943
Near Farmington, Mo.

19. UNDERTAKER C. H. Cozear
(ADDRESS) Farmington, Mo.

20. FILED Dec 13 1943 Byndie Buhmester
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 4, 1943

22. I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1943, 19, to Dec. 4, 1943, 19

I last saw her alive on December 4, 1943. Death is said to have occurred on the date stated above, at 2:10 P. M.

The principal cause of death and related causes of importance were as follows:

Inoperable abdominal Ca. Date of onset

Other contributory causes of importance:

Name of operation None Date of

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) M. D. ...
(Address) 408 1/2 ... Farmington, Mo.

RECEIVED

District Health Officer No. 4
District File Number 144-3127
Date Filed 1-5-44

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 me, Registered Apprentice No. _____, working under my personal supervision.

Signed C. Hozean

Licensed Embalmer No. 4084

P. O. Address Farmington Mo.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jon
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

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

1. PLACE OF DEATH:
(a) County St. Francois
(b) City or town Russell
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
State Hosp. No. 4
(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) PRINT FULL NAME Caroline Freeman
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 W

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

7. Birth date of deceased May 10 1886
(Month) (Day) (Year)

8. AGE: Years 76 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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 _____
(Burial, cremation, or removal) (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 Dec Day 4 Year 1943 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Inoperable abdominal Ca.

Due to Primary not known
was 5 days prior to death.

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy 552

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 M. J. [Signature] (M. D. or other) 206

Address 408 2nd [Signature] Date signed 1-17-44

SUPPLEMENTARY

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

5-42582