

FILED FEB 7 1944

Registration District No. \_\_\_\_\_

Primary Registration District No. 5802

Registrar's No. 5

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

1. PLACE OF DEATH:

(a) County Marion  
 (b) City or town Rural Woodlawn  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Rural  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)  
 In this community ENTIRE LIFE  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Marion  
 (c) City or town Rural  
(If outside city or town limits, write "RURAL")  
 (d) Street No. South of Woodlawn  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Marvin Letrick Freeman

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 divorced

6. (b) Name of husband or wife Carabelle Freeman 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased June 23 1875  
(Month) (Day) (Year)

8. AGE: Years 68 Months 6 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Robert Freeman  
 13. Birthplace Mo  
(City, town, or county) (State or foreign country)  
 14. Maiden name FRANCIS  
 15. Birthplace Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Robt Freeman  
 (b) Address Havenport, Ia

17. (a) BURIAL (b) Date thereof Jan 18 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Woodlawn

18. (a) Signature of funeral director C. E. Lappin  
 (b) Address \_\_\_\_\_

19. (a) 1-25-44 (b) Otis H. Sabery  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 18 year 1944 hour 8 minute 30 A.M.

21. I hereby certify that I attended the deceased from Jan 18 to Dec 28 1943  
 that I last saw him alive on Dec 28 and that death occurred on the date and hour stated above.

Immediate cause of death chronic myocarditis  
 Duration n.k.

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (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? \_\_\_\_\_  
(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 F. A. Barnett (M. D. or other) MO  
 Address Paris, Mo Date signed \_\_\_\_\_

RECEIVED

District Health Officer No. 10

District File Number 2-44-276

Date Filed FEB 5 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.....

Licensed Embalmer No. 72610

P. O. Address..... Blair 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.

State File No. \_\_\_\_\_

Registration District No. 226

Primary Registration District No. 5802

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Marion  
(b) City or town Paris - Woodlawn Twp  
(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) PRINT FULL NAME Marvin S. Freeman

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

7. Birth date of deceased: June 23 1874  
(Month) (Day) (Year)

8. AGE: Years 68 Months 6 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (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: \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director Otto Hedberg

(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 \_\_\_\_\_ Day \_\_\_\_\_  
year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;

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

Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

3646