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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED FEB 9 1844  
275

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3927

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

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

Primary Registration District No. 3053

Registrar's No. 6

1. PLACE OF DEATH:

(a) County Shelby

(b) City or town Relea

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

(d) Length of stay: In hospital or institution 5 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Reynolds

(c) City or town Osceola  
(If outside city or town limits, write "RURAL")

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

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Isabel Freeman

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 5  
year 1944 hour 7 minute 00 A.M.

21. I hereby certify that I attended the deceased from Jan 1 1944 to Jan 5 1944  
that I last saw him alive on Jan 5 1944  
and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife Samuel Freeman live \_\_\_\_\_ years

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

7. Birth date of deceased Apr 23 1894  
(Month) (Day) (Year)

Immediate cause of death Person over the liver

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

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

Other conditions (include pregnancy within 3 months of death) 46 f

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

8. AGE: Years 49 Months 8 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

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

12. Name Jim Foster

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

14. Maiden name Sarah Mayers

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

16. (a) Informant Samuel Freeman

(b) Address Relea Mo

17. (a) Rural (b) Date thereof 1-6-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Meyer bur

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

(b) Address Relea Mo

19. (a) 1-5-44 (b) J. ...  
(Date received local registrar) (Registrar's signature)

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 1-5-44

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

MOTHER FATHER

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

**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..... *D. B. Jones*  
Licensed Embalmer No. *3297*  
P. O. Address..... *Kalla 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.**