

No. 2  
8-43  
17-39  
X37829

FILED MAY 24 1944  
Registration District No. 42

Primary Registration District No. 6000

State File No. ....

Registrar's No. 487

1. PLACE OF DEATH:

(a) County Buchanan County

(b) City or town St. Joseph, Missouri.

(c) Name of hospital or institution:  
1018 Olive Street-

(d) Length of stay: In hospital or institution \_\_\_\_\_

In this community Nearly entire life.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph

(d) Street No. 1018 Olive Street,

(e) Citizen of foreign country? Yes

If yes, name country Norway.

3. (a) PRINT FULL NAME MAGNUS NELSON FREEBURG.

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE-

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day third

1944 year hour 7 minute 50 A.M.

4. Sex Male

5. Color or race White

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: July 5th. 1864

21. I hereby certify that I attended the deceased from Apr. 2, 1944, to Apr. 3, 1944; that I last saw him alive on April 2, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death: Hepatic Carcinoma

Duration 2yrs.

8. AGE: Years 80' Months 8 Days 20

If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

9. Birthplace Norway 4

(City, town, or county) (State or foreign country)

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

10. Usual occupation Gardener.

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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

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

12. Name Nelson Freeburg.

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

13. Birthplace Sweden. 4

(City, town, or county) (State or foreign country)

14. Maiden name Innia Freeburg.

15. Birthplace Germany. 4

(City, town, or county) (State or foreign country)

16. (a) Informant Social Security Board.

(b) Address Tenth & Patee Streets

17. (a) B (b) Date thereof 4/16/44

(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Mrs. E. R. Sidenfaden

(b) Address 602 South 10th Street

19. (a) 4/5/44 (b) Rose Hazy

(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 J. R. Elliott (M. D. or other) M.D.

Address 801 Francis St. Joseph Date signed 4-1-44

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

MOTHER FATHER

1233

**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

*Mollie E. Sidenfaden*

Licensed Embalmer No.

*4235*

P. O. Address.....

*St. Joseph M*

**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.**