

FILED JAN 8 1945

State File No. _____

Registration District No. 295

Primary Registration District No. 6014

Registrar's No. 57

1. PLACE OF DEATH:

(a) County Randolph *Monteau*

(b) City or town Roanoke *Roanoke - Stanton Twp*

(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 X 1

In this community Since 1903 (Specify whether years, months or days)

3. (a) PRINT FULL NAME James Buchanan Freeman

3. (b) If veteran, name war X

3. (c) Social Security No. _____

4. Sex M 0

5. Color or race White

6. (a) Single, widowed, married, divorced yes 2

6. (b) Name of husband or wife Sarah Jane Freeman

6. (c) Age of husband or wife if alive X 56 years

7. Birth date of deceased March 3 1886

(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>88</u>	<u>9</u>	<u>25</u>	hr. _____ min. _____

9. Birthplace Carroll Co. Virginia

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

10. Usual occupation Farmer & carpenter

11. Industry or business _____

MOTHER FATHER

12. Name Larkin Freeman

13. Birthplace Patriek Co. Virginia

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

14. Maiden name Frances Kirkbride

15. Birthplace Carroll Co. Virginia

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

16. (a) Informant Mrs. Lillian Freeman

(b) Address Armstrong, Missouri

17. (a) Burial (b) Date thereof Dec. 30 '44

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

(c) Place: burial or cremation Roanoke Cemetery

18. (a) Signature of funeral director Mary Oldaker

(b) Address Armstrong, Mo.

19. (a) 1-3-45 (b) Mrs. P. D. Dwyer

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howard 45

(c) City or town Armstrong 0

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

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

(e) If foreign born, how long in U. S. A.? X 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 28th

year 1944 hour 8 minute 10 P. M.

21. I hereby certify that I attended the deceased from Dec 25

6, 1944, to Dec 28, 1944;

that I last saw him alive on Dec. 25, 1944

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

Immediate cause of death Chronic interstitial nephritis

Due to Chronic Nephritis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: 131

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 0

23. Signature M. M. Diederich (M. D. or other)

Address Armstrong, Mo Date signed 12/30/44

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

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RECEIVED

State Health Office No. 10

Division of Health No. 1-45-14

Date Filed JAN 5 1945

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 Mary Oldaker

Licensed Embalmer No. 3399

P. O. Address Armstrong, 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, above space should be left blank.