No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 19 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

9517

State File No.

Registration District No. 93

Primary Registration District No. 4154

Registrar's No. 78

1. PLACE OF DEATH:

(a) County Dade

(b) City or town Greenfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ✓ (Specify whether

In this community 71 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dade 29

(c) City or town Greenfield 1
(If outside city or town limits, write "RURAL")

(d) Street No. City 0
(If rural, give location)

(e) Citizen of foreign country? ✓ 0 (Yes or No)

If yes, name country ✓

3. (a) PRINT FULL NAME GEORGE FREEDLE

3. (b) If veteran, name war No

3. (c) Social Security No.

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced DIVORCED

6. (b) Name of husband or wife ✓

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

7. Birth date of deceased November (Month) 14 (Day) 1873 (Year)

8. AGE:

Years	Months	Days	If less than one day
71	3	11	hr. min.

9. Birthplace Dade Co. (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Plumber

11. Industry or business Plumbing

FATHER
12. Name George Freedle
13. Birthplace No Record 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Shaw
15. Birthplace No Record 9 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Phyllis Lack

(b) Address Greenfield Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-1945 (Month) (Day) (Year)

(c) Place: burial or cremation Greenfield Cemetery

18. (a) Signature of funeral director Sam E. Senseney Jr

(b) Address Greenfield Mo.

19. (a) 2/28/45 (Date received local registrar) (b) Phyllis Lack. (Registrar's signature)

10 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 25 year 1945 hour 5 minute A. M.

21. I hereby certify that I attended the deceased from Jan 1, 1945, 19, to Feb 25, 1945, that I last saw him alive on Feb. 17, 1945, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Embolism (Coronary)	
Due to Basal Cell Carcinoma	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Hershel Thockey (M.D. or other) D.D.

Address Greenfield Date signed 2-28-45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 34 S-267
Date Filed MAR 13 1945

NOV 14 1950

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 Sam C. Sensenney Jr.

Licensed Embalmer No. 4099

P. O. Address Springfield, 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.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 93 Primary Registration District No. 4154 Registrar's No. 78

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Dade

(b) City or town Greenfield
(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)

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

3. (a) PRINT FULL NAME George Freedle

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 D

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov (Month) 14 (Day) 1873 (Year)

8. AGE: Years 71 Months 3 Days 1 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 21 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Embolus (cerebral)

Due to Basal cell Carcinoma of larynx & trachea

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

47a

ADDITIONAL SUPPLEMENTARY INFORMATION

Duration

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Hershel Shockey (M.D. or other) D.O.

Address Greenfield Date signed 3-19-45

9517