

3. No. 2
M-2-43
5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 16 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37556

State File No. _____

Registration District No. 136

Primary Registration District No. 2001

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jasper

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

(c) Name of hospital or institution:
2308 Byers Ave.
(If not in hospital or institution, write street number or location)

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

In this community 37 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper

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

(d) Street No. 2308 Byers Ave.
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Ray Stanley Freeland

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife Ola Freeland

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Oct. 22, 1886
(Month) (Day) (Year)

8. AGE: Years 59 Months 0 Days 3

If less than one day _____ hr. _____ min.

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

10. Usual occupation Post Office Clerk.

11. Industry or business _____

MOTHER FATHER { 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 Mrs R S Freeland

(b) Address 2308 Byers Ave. Joplin Mo.

17. (a) Burial (b) Date thereof Oct. 26 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope Cem.

18. (a) Signature of funeral director Hurlbut Und. Co.

(b) Address Joplin Mo.

19. (a) 10-27-45 (b) Ed Thomas
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct 25, day 1945
year _____ hour 12-15 P. Minute _____ M.

21. I hereby certify that I attended the deceased from Oct. 24-45
_____ 1945 to Oct. 25 1945
that I last saw him alive on Oct. 24 1945
and that death occurred on the date and hour stated above.

Immediate cause of death:
Coronary occlusion (Thrombosis)

Due to Coronary atherosclerosis with thrombosis 5 yrs.

Due to 90.

Hypertension - many yrs.

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 Ed Thomas (M. D. or other)
Address Joplin Mo. Date signed 10/26/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

45-10-839

NOV 26 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 *Jerry K. Furlbert*

Licensed Embalmer No. *959*

P. O. Address *Joplin 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.

Registration District No. (156)

Primary Registration District No. (2001)

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Jasper
(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 (Specify whether _____)

3. (a) PRINT FULL NAME Ray S. Freeland

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 _____

7. Birth date of deceased Oct 22
(Month) (Day) (Year)

8. AGE: Years 59 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Unknown
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) _____ (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) _____ (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 Dec Day 20 Year 1941 (hour) _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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

37556