

FILED DEC 12 1945

Registration District No. 217

Primary Registration District No. 3045

Registrar's No. 83

1. PLACE OF DEATH:

(a) County Mississippi

(b) City or town Charleston

(c) Name of hospital or institution: 310 North Heggie /
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution...
All Of Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Miss. 69

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

(d) Street No. 310 North Heggie
(If rural, give location)

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

If yes, name country None

3. (a) PRINT FULL NAME Ora Belle Freeland

3. (b) If veteran, name war: ---

3. (c) Social Security No. ---

4. Sex F / 5. Color or race White

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

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

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased June 14th 1893
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>52</u>	<u>6</u>	<u>01</u>	hr. min.

9. Birthplace Mississippi Co Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name William Hunt

13. Birthplace N.K. Illinois /
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Harris

15. Birthplace N.K. N.Y. /
(City, town, or county) (State or foreign country)

16. (a) Informant Charlesy Freeland

(b) Address Charleston, Mo.

17. (a) Burial (b) Date thereof 11-7-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove, Charleston, Mo.

18. (a) Signature of funeral director John P. Thumelle

(b) Address Charleston Mo

19. (a) 11/13/45 (b) Mrs. John Bondurant
(Date received local registrar) (Registrar's signature)

15 91

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 5th
year 1945 hour 6 minute Am M.

21. I hereby certify that I attended the deceased from 10-27, 1945 to 11-5, 1945
that I last saw her alive on 11-4, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of liver 3 Mo

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy HOK

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? Mo.

While at work? (Specify type of place) (e) Means of injury

23. Signature H. P. Fenton (M.D. or other)

Address Wyatt Mo Date signed 1-5-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

67
1
2

RECEIVED

District Health Office No. 2,

District File Number 1245-3350

Date Filed 12/6/45

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 John F. Finneley

Licensed Embalmer No. 3851

P. O. Address Charleston, 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.