

FILED JAN 20 1946

Primary Registration District No. **2000**

Registrar's No. **1056**

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **Springfield**
(c) Name of hospital or institution: **Springfield Baptist Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8 da.**
In this community _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME

Harry Samuel Freese

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **m.** 5. Color or race **wht** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Ida Katie Freese** 6. (c) Age of husband or wife if alive **67** years

7. Birth date of deceased **Jan 1 1880**
(Month) (Day) (Year)

8. AGE: Years **66** Months **11** Days **19**
If less than one day hr. _____ min. _____

9. Birthplace **Nebraska City, Nebr.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **Peter Harrison Freese**

13. Birthplace **Three Rivers, Mich. Penn.**
(City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Keith**

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

16. (a) Informant **Mrs. Katie Freese**

(b) Address **Box 1000, Mo.**

17. (a) **Removed** (b) Date thereof **12-31-46.**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Nebraska City, Nebr.**

18. (a) Signature of funeral director **Chas. H. Beard**

(b) Address **W. M. S.**

19. (a) **12-31-46** (b) **W. J. Handley, M.D.**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Douglas**
(c) City or town **Dora 'Rural'**
(If outside city or town limits, write "RURAL")
(d) Street No. **None** (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 **31**
year **1946** hour **7** minute **20 a.m.**

21. I hereby certify that I attended the deceased from **Dec 23 1946** to **Dec 31 1946**
that I last saw him alive on **Dec 30 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Prostatic Hypertrophy**
Probable Carcinoma

Due to _____

Due to _____

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) Means of injury _____

23. Signature **James E. Henry** (M. D. optional)
Address **Springfield, Mo.** Date signed **Dec 31 1946**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

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.....

W B Hutchins

Licensed Embalmer No.....

3431

P. O. Address.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb
Registrar's No. 1056

Registration District No. 128 Primary Registration District No. 2001

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(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

3. (a) PRINT FULL NAME

Harry S. Freese
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 _____ years

7. Birth date of deceased Jan 1 (Month) 1901 (Day) _____ (Year)

8. AGE: 66 Years 6 Months 2 Days if less than one day _____ hr _____ min.

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

10. Usual occupation _____

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 _____ (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 _____ Day _____ Year 1967 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____ that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above. Immediate cause of death _____ Duration _____

Other conditions _____ (Include pregnancy within 3 months of death)
Due to _____
Due to _____

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

42286

S-43478