

No. 2
-12-45
5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 577

FILED JAN 21 1947

Registration District No. 72

Primary Registration District No. 4289

Registrar's No. 4

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

1. PLACE OF DEATH:

(a) County Clay

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

(c) Name of hospital or institution: R.R.#8
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. Home on farm
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay

(c) City or town North Kansas City Mo
(If outside city or town limits, write "RURAL")

(d) Street No. R.F.D.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Max C. Freeman

3. (b) If veteran, name war World war 1

3. (c) Social Security No. 495-07-8185

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 4
year 1947 hour 6:00 minute 00 P.M.

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

4. Sex male 5. Color or race W

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

6. (b) Name of husband or wife Janis R. Freeman

6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased Jan 9 1900
(Month) (Day) (Year)

Immediate cause of death Gun shot from 38 caliber revolver

Duration _____

8. AGE:	Years	Months	Days	If less than one day
	<u>46</u>	<u>11</u>	<u>25</u>	_____ hr. _____ min.

Due to _____

Due to _____

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

10. Usual occupation Police K.C. Mo

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

11. Industry or business _____

12. Name Jessie Murre Frengue

13. Birthplace unknown
(City, town, or county) (State or foreign country)

14. Maiden name Martha Jane Brown

15. Birthplace Gasport Indiana
(City, town, or county) (State or foreign country)

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Mary Freeman

(b) Address Lakewood Jaycourse Mo

17. (a) Removal (b) Date thereof 10-6-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hill Country Store McChes

18. (a) Signature of funeral director Malcolm Smith

(b) Address 833 W. 11th St. Mo

19. (a) Jan 6 - 1947 (b) Beulah Kitcher
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Homicide

(b) Date of occurrence Jan 4 - 1947

(c) Where did injury occur? R.F.D. #1, K.C. Clay Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home on farm
While at work? _____ (Specify type of place)

(e) Means of injury Gun shot

23. Signature P.W. Prother (M. D. or other) _____
Address Epelion Springs Mo Date signed 1-6-47

RECEIVED
District Health Officer No. 8,
District File Number _____
Date Filed 1-18-47

MAR 7 1947

JAN 29 1947
JAN 28 1947

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 Theron O. Smith
Licensed Embalmer No. 3928
P. O. Address North Kansas City

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.