

FILED APR 23 1947
128

Registration District No. **128**

Primary Registration District No. **2000**

Registrar's No. **249 A**

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: **St. John's Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 WEEKS - 1 DAY**
In this community **10 WEEKS - 1 DAY** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **Greene** **39**
(c) City or town **SPRINGFIELD**
(If outside city or town limits, write "RURAL")
(d) Street No. **ST. JOHN'S HOSPITAL** **6**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME **JAMES FREEMAN**

3. (b) If veteran, name war **NONP** 3. (c) Social Security No. **NONP**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOWED**

6. (b) Name of husband or wife **SARA H. FREEMAN** 6. (c) Age of husband or wife if alive **20** years

7. Birth date of deceased **MAY 30 1854**
(Month) (Day) (Year)

8. AGE: Years **92** Months **9** Days **27** If less than one day **hr. min.**

9. Birthplace **DOUGLAS CO MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **FACTOR - RETIRED**

11. Industry or business

MOTHER FATHER { 12. Name **NOT KNOWN**
13. Birthplace **unknown TENN.**
(City, town, or county) (State or foreign country)
14. Maiden name **NOT KNOWN**
15. Birthplace **NOT KNOWN** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Nesha Freeman**

(b) Address **Mansfield Mo**
17. (a) **BURIAL** (b) Date thereof **MAY 19 - 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MANSFIELD MO**

18. (a) Signature of funeral director **Ed. Steffe**

(b) Address **MANSFIELD MO**

19. (a) **3-19-47** (b) **W. Handley, M.D.**
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MARCH** day **17**
year **1947** hour **12** minute **45 AM**

21. I hereby certify that I attended the deceased from **Jan 6, 1947**
2 19 **to MAR 17** 1947;
that I last saw him alive on **Mar 16** 1947
and that death occurred on the date and hour stated above.

Immediate cause of death **Bilateral Broncho pneumonia**
48 hrs

Due to

Due to

Other conditions **Fracture, intertrochanteric**
(Include pregnancy within 3 months of death)
R-Tumor (10 wks)

Major findings: **186**

Of operations

Of autopsy

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

(a) Accident, suicide, or homicide (specify) **accident 114**

(b) Date of occurrence **11/4/47**

(c) Where did injury occur? **Mansfield Mo.**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home

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

23. Signature **James D. Horton** (M. D. or other) **0**
Address **Springfield, Mo.** Date signed **3/17/47**

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

39
2
6

MAR 25 1968

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.C. Steffe
Licensed Embalmer No. 3221
P. O. Address. Manfield 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.