

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 5 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25224
Registrar's No. 244

Registration District No. 316 Primary Registration District No. 6073

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

1. PLACE OF DEATH:
(a) County. St. Francois
(b) City or town. Farmington RTD 4
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(Rural - Perry Township)
(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 _____ days

3. (a) PRINT FULL NAME Bhas S Freeman
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 married

6. (b) Name of husband or wife Vera Freeman 6. (c) Age of husband or wife if alive 49 years
7. Birth date of deceased June 30 1888
(Month) (Day) (Year)

8. AGE: Years 59 Months 1 Days - If less than one day _____ hr. _____ min.

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

10. Usual occupation _____ 11. Industry or business Farmer

12. Name S Freeman

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

14. Maiden name Martha Work

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

16. (a) Informant Vera Freeman
(b) Address Farmington RTD 4

17. (a) Burial (b) Date thereof 7-15-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bismarck, Mo
18. (a) Signature of funeral director Baldwell
(b) Address Flat River Mo

19. (a) 7-21-47 (b) Ether Rudloff
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State. Missouri (b) County. St. Francois
(c) City or town. Farmington RTD 4
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 13th day July
year 1947 hour about 1 minute 7 A. 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.

Immediate cause of death Cerebral Hemorrhage
Duration 3-4 hours

Due to Mr. Freeman was found dead at 5:30 P.M. Cause of death determined by pathologist as reported to coroner physician permission to sign certificate
Other conditions: sign certificate
(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? 2

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature W.D. Kellum (M. D. or other) Dr
Address Flat River Mo Date signed 7/16/47

RECEIVED

District Health Officer No. 4

District File Number 847-1006

Date Filed 8-4-47

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.A. Baldwin
Licensed Embalmer No. 3317
P. O. Address Flat River on

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.