

FILED FEB 14 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

878

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5466 Registrar's No. 97

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Oklahoma</b> b. COUNTY <b>Tulsa</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>S. Campbell Twp. Rural</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Bixby</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Medical Center for Federal Prisoners</b>		d. STREET ADDRESS (If rural, give location) <b>8</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>MAJOR</b> b. (Middle) <b>--</b> c. (Last) <b>FREEMAN</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 7, 1951</b>	
5. SEX <b>Male 4</b>	6. COLOR OR RACE <b>Indian</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married 1</b>	8. DATE OF BIRTH <b>Yr. 1871 month unknown</b>
9. AGE (In years last birthday) <b>80</b>		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>VARIED</b>	11. BIRTHPLACE (State or foreign country) <b>Territory of Oklahoma 1</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13a. FATHER'S NAME <b>Unknown</b>	
13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Alice Fox</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>File, MCFP, Springfield, Missouri</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hematemesis due to undetermined cause</b> INTERVAL BETWEEN ONSET AND DEATH <b>72-hrs.</b>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Arteriosclerotic heart disease. Cholelithiasis.</b>		<b>584X</b>	
19a. DATE OF OPERATION <b>2-6-51</b>		19b. MAJOR FINDINGS OF OPERATION <b>Cholelithiasis</b>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Sept. 30, 1933</b> , to <b>Feb. 7, 1951</b> , that I last saw the deceased alive on <b>Feb. 7, 1951</b> , and that death occurred at <b>7:00 P.m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>E. C. Rinck</b> (Degree or title) <b>E. C. RINCK, M.D., Clinical Director</b>		23b. ADDRESS <b>Medical Center for Federal Prisoners Springfield, Mo.</b>	
23c. DATE SIGNED <b>2-8-51</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVED</b>	
24b. DATE <b>2/11/51</b>		24c. NAME OF CEMETERY OR CREMATORY <b>UNKNOWN</b>	
24d. LOCATION (City, town, or county) (State) <b>Bixby Okla</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>W. H. Solmeyer, Springfield Mo</b>	
DATE REC'D BY LOCAL REG. <b>2-8-51</b>		REGISTRAR'S SIGNATURE <b>W. H. Solmeyer</b>	

WRITE PLAINLY—USING 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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *W. L. McC. Coover*

Licensed Embalmer No. 2727

P. O. Address Springfield 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.