S. No. 300
V. 10.48

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13659

FILED MAY 8 1952

BIRTH NO. _____ REG. DIST. NO. 237 PRIMARY REG. DIST. NO. 4353 Registrar's No. 10

1. PLACE OF DEATH
a. COUNTY: New Madrid
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gideon
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: New Madrid
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gideon 0724
d. STREET ADDRESS (If rural, give location): 0

3. NAME OF DECEASED (Type or Print)
a. (First): Berdie
b. (Middle): Ellen
c. (Last): Freeman

4. DATE OF DEATH (Month) (Day) (Year): May 6, 1952

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 9-4-1902
9. AGE (In years last birthday): 47 — If under 1 year: Months 8, Days 2, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Houston, Arkansas
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Robert Jones
13b. MOTHER'S MAIDEN NAME: ~~Mary~~ Mary E. Brikey
14. NAME OF HUSBAND OR WIFE: Henry F. Freeman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: H. H. Freeman — **ADDRESS**: Gideon Mo

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Septicaemia — INTERVAL BETWEEN ONSET AND DEATH: 3 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Abdominal Abscess — 12/19/51
DUE TO (c): Ruptured Appendix — 12/1/1951

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 1/10/1952
19b. MAJOR FINDINGS OF OPERATION: Appendicial Abscess 5501
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): No
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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 12/19/51, *to* 5-6-52, *that I last saw the deceased alive on* 5-4-52, *and that death occurred at* 9:55 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: L. E. Mitchell — (Degree or title): M.D. — **23b. ADDRESS**: Malden Mo — **23c. DATE SIGNED**: 5/6/52

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 5-7-1952
24c. NAME OF CEMETERY OR CREMATORY: New Malden
24d. LOCATION (City, town, or county) (State): Near Malden, Mo.

DATE REC'D BY LOCAL REG.: 5-6-52
REGISTRAR'S SIGNATURE: Mrs. F. G. Hopkins
25. FUNERAL DIRECTOR'S SIGNATURE: Floyd M. Russell — **ADDRESS**: Puggott Mo.

(Licensed Embalmer's Statement on Reverse Side)

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~~ me

....., Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed Lloyd Russell

Licensed Embalmer No. 502 - Ark

P. O. Address Piggott, Ark

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.