

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **33028**

FILED OCT 18 1954

BIRTH NO. _____		REG. DIST. NO. <b>38</b>		PRIMARY REG. DIST. NO. <b>5118</b>		Registrar's No. <b>280</b>			
1. PLACE OF DEATH a. COUNTY <b>Boone</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <b>Missouri</b> b. COUNTY <b>Boone</b>					
b. CITY OR TOWN <b>Rural, Missouri Tws.</b>		c. LENGTH OF STAY (in this place) <b>22yrs</b>		c. CITY OR TOWN <b>Rocheport, Route 1</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Rocheport Route 1</b>				STREET ADDRESS (If rural, give location) <b>12 Mi. N.W. Columbia</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>Robert</b> b. (Middle) <b>E. Lee</b> c. (Last) <b>Freese</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 11, 1954</b>						
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Nov. 17, 1870</b>		9. AGE (In years last birthday) <b>83</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 HR. Hours	IF UNDER 15 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13a. FATHER'S NAME <b>P. W. Freese</b>			13b. MOTHER'S MAIDEN NAME <b>America Russell</b>		14. NAME OF HUSBAND OR WIFE <b>Nancy Rowena Freese</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>----</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Austin Freese, Rocheport, Route Mo</b>				ADDRESS	
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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Abdominal Prognatosis, origin undetermined</b>						INTERVAL BETWEEN ONSET AND DEATH <b>about 6 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.								
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					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) (Min.)		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>23 July, 1954, to 11 Oct, 1954</b> , that I last saw the deceased alive on <b>31 Aug, 1954</b> , and that death occurred at <b>12:45 P. M.</b> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>Honore E. Thomas M.D.</b>			23b. ADDRESS <b>Columbia, Mo</b>			23c. DATE SIGNED <b>12 Oct. 1954</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>10/13/1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		24d. LOCATION (City, town, or county) (State) <b>Columbia, Mo</b>				
DATE REC'D BY LOCAL REG. <b>Oct 13 1954</b>		REGISTRAR'S SIGNATURE <b>Mrs. R.E. Palmer</b>		31-0		25. FUNERAL DIRECTOR'S SIGNATURE <b>Lyman Spunkle</b>		ADDRESS <b>Memorial Funeral Home, Columbia, Mo.</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

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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.....  
Signature of Student Embalmer

Signed *Lyman H. Sprinkle*

Licensed Embalmer No. *401*

P. O. Address *Columbia*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.