

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

XC-347 82 24  
RN 9620 FILED MAY - 9 1957

State File No. 29090A  
Registrar's No. 321

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 3007

|  |                               |   |   |
|--|-------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Butler</b>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>--a. STATE <b>Arkansas</b> b. COUNTY <b>Greene</b> |   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Poplar Bluff</b>                               |                               | c. CITY OR TOWN <b>Paragould</b>  | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (in this place) <b>1 day</b>   |                               | e. STREET ADDRESS (If rural, give location) <b>227 Lake St.,</b>  |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>VA Hospital</b>   |                               |   |   |
| 3. NAME OF DECEASED (Type or Print) a. (First) <b>LESTER</b> b. (Middle) <b>GRANT</b> c. (Last) <b>FREEMAN</b>                 |                               | 4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 5, 1955</b>   |   |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>  | 8. DATE OF BIRTH <b>Unknown</b>   |
| 9. AGE (In years last birthday) <b>46</b>  |                               | 10. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>  | 11. BIRTHPLACE (City and State or Foreign Country) <b>Jonesboro, Ark.</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver Helper</b>         |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   |
| 13a. FATHER'S NAME <b>William Freeman</b>  |                               | 13b. MOTHER'S MAIDEN NAME <b>Alice Randolph</b>   | 14. NAME OF HUSBAND OR WIFE <b>None</b>   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>WWI</b> |                               | 16. SOCIAL SECURITY NO. <b>UNKNOWN</b>  | 17. INFORMANT'S SIGNATURE OR NAME <b>VA Hospital Records</b> ADDRESS _____  |

|   |  |  |  |                                  |
|---|--|--|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a); (b), and (c)   |  | MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusion</b>  |  |  |  |                                  |
| *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. |  | 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) <b>VA</b> | 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 Aug 5, 1955, to Aug 5, 1955, and that death occurred at 2:48 pm., from the causes and on the date stated above.

|   |  |   |  |
|---|--|---|--|
| 23a. SIGNATURE (Type or Print) <b>E. D. BASKETT, M.D., Chief Med. Sv.</b> |  | 23b. ADDRESS <b>VA Hospital Poplar Bluff, Mo.</b>                                       | 23c. DATE SIGNED <b>8-8-55</b>   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>                   | 24b. DATE <b>8/7/1955</b>                | 24c. NAME OF CEMETERY OR CREMATORY <b>Linwood Cemetery</b>                              | 24d. LOCATION (City, town, or county) (State) <b>Paragould, Greene, Ark.</b> |
| DATE REC'D BY LOCAL REG. <b>4/30/57</b>                                   | REGISTRAR'S SIGNATURE <b>[Signature]</b> | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Heath Funeral Home Paragould, Ark</b> ADDRESS _____ |  |

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

RECEIVED

MAY 6 1957

BUTLER CO. HEALTH CENTER

FILE No. \_\_\_\_\_

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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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**Note:** The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.