Health, Welfare Public Service

300-3
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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-001652
STATE FILE NUMBER

FILED JAN 27 195

Registration District No. 146 Primary Registration District No. 4237 Registrar's No. 31

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Raytown — Inside Limits Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 9500 E. U.S.50 — Length of stay in Ib 30 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 3226 Charlotte — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First Richard Middle H. Last Freed
4. DATE OF DEATH Month Jan. Day 17, Year 1959
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Jan.30,1928
9. AGE (In years last birthday) 30 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Kansas City Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Theodore Freed
13b. MOTHER'S MAIDEN NAME Lillian Hay
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) Korean
16. SOCIAL SECURITY NO. 496-24-6522
17. INFORMANT Address Mrs.Lillian Freed 3226 Charlotte

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Crushing injury of head
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Skull fracture
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☑ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) car accident
20c. TIME OF INJURY 12-03 Hour a.m. p.m. Month, Day, Year 1-17-59
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) highway
20f. CITY, TOWN, OR LOCATION Raytown COUNTY Jackson STATE Mo

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Deputy Coroner
22b. ADDRESS 6623 Prospect K.C. Mo.
22c. DATE SIGNED 1-18-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 1/19/59
23c. NAME OF CEMETERY OR CREMATORY Greenlawn
23d. LOCATION (City, town, or county) Kansas City (State) Mo.

24. FUNERAL DIRECTOR Stine & McClure ADDRESS K.C.Mo.
25. DATE RECD. BY LOCAL REG. 1-19-59
26. REGISTRAR'S SIGNATURE

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

FEB 8 - 1959

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 E Clark Hegert

Licensed Embalmer No. 3983

P. O. Address Raytown 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.