Health, Welfare & Public Service

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-012546
STATE FILE NUMBER

FILED MAY 5 1959 Registration District No. 47 Primary Registration District No. 4067 Registrar's No. 126

1. PLACE OF DEATH
a. COUNTY: Callaway
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Auxvasse — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Home — Length of stay in Hospital: 10 Yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Callaway
c. CITY OR TOWN: Auxvasse — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 0140 — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: William Middle: E. Last: Freeman

4. DATE OF DEATH Month: April Day: 25 Year: 1959

5. SEX: Male **6. COLOR OR RACE:** White **7. MARITAL STATUS:** MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: Oct, 28, 1878

9. AGE (In years last birthday): 80 — 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): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (City and state or country): Callaway County, Mo
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: John Freeman
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Ruby Freeman, deceased

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 491-14-262
17. INFORMANT: Leo Freeman Address: Mexico, Mo

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Hypertension — 1 yr to my knowledge
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Hemiplegia 1 yr. ago. 4201
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
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.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1940, to April 25-59 and last saw he/him alive on April 26-59
Death occurred at 7 am on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [signature]
22b. ADDRESS: Auxvasse Mo
22c. DATE SIGNED: 4-26-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Apr, 27, 1959
23c. NAME OF CEMETERY OR CREMATORY: East Lawn Memorial Park
23d. LOCATION (City, town, or county) (State): Mexico. Mo

24. FUNERAL DIRECTOR ADDRESS: Arnold Funeral Home, Mexico, Mo
25. DATE RECD. BY LOCAL REG.: April 27-1959
26. REGISTRAR'S SIGNATURE: Maretta Lawrence

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

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 Rex Miller

Licensed Embalmer No. 4492

P. O. Address Mexico, 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.