

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

**1. PLACE OF DEATH**

County Monroe  
Township Jefferson  
City Paris (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 588  
Primary Registration District No. 5781

File No. 25290  
Registered No. 7  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

James Robert Freeman

(a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF  
Earna Freeman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 15 - 1878

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>50</u>	<u>10</u>	<u>8</u>	

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer Self

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) Missouri

PARENTS	10. NAME OF FATHER <u>James M. Freeman</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Missouri</u>
	12. MAIDEN NAME OF MOTHER <u>Martha Green</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Missouri</u>

14. INFORMANT F. L. Freeman  
(Address) West City Mo

15. FILED 8/17 1929 W. I. Bell REGISTRAR

**2. MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/23 1929

17. I HEREBY CERTIFY, That I attended deceased from July 20 1929 to July 23 1929 that I last saw him alive on July 22 1929 and that death occurred, on the date stated above, at 4:30 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Acute nephritis  
120  
1929 (duration) 3 yrs. 10 mos. 10 ds.

CONTRIBUTORY (SECONDARY) Chronic Bronchitis  
(duration) 1 yrs. 3 mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

0 WAS THERE AN AUTOPSY? no

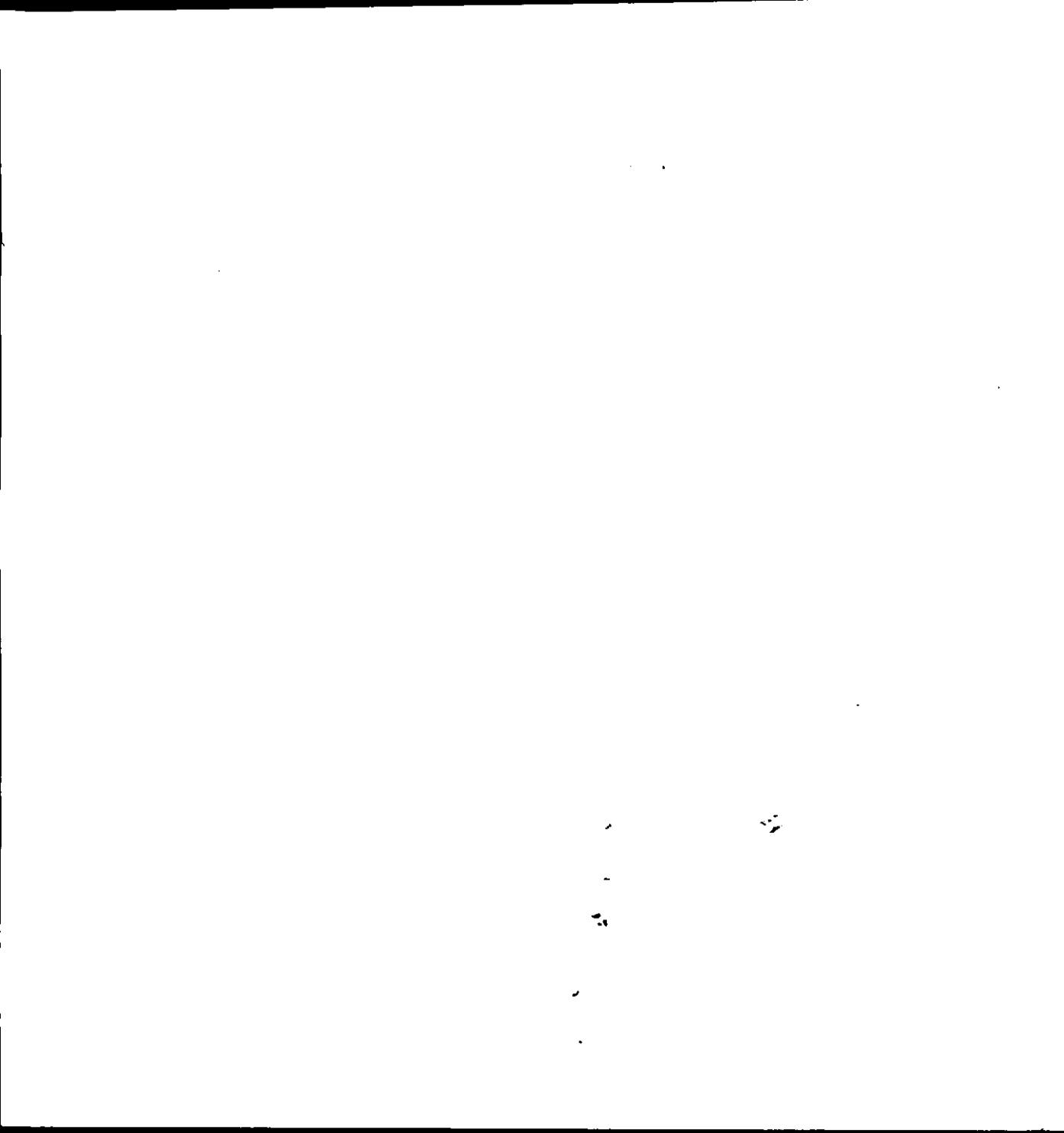
WHAT TEST CONFIRMED DIAGNOSIS Cerebral Artery  
(Signed) W. E. Taylor M. D.

7/23 1929 (Address) Paris, Mo.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Scobbe Cemetery DATE OF BURIAL July 25 1929

20. UNDERTAKER Speed & Blakeney ADDRESS Paris Mo



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Monroe Registration District No. 583 File No. ....  
 Township Jefferson Primary Registration District No. 5781 Registered No. 7  
 City Jefferson (No. ....) St. .... Ward .....

**2. FULL NAME**

James Robert Freeman  
 (a) Residence No. .... St. .... Ward. ....  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .... hrs. or .... min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

PARENTS  
 10. NAME OF FATHER  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)  
 12. MAIDEN NAME OF MOTHER  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 8/7 1929 G. T. Bell REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 23 1929

17. I HEREBY CERTIFY That I attended deceased from 19... to 19... that I last saw h... alive on 19..., and that death occurred, on the date stated above, at .....

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Acute Diphtheria  
caused in Brown  
 (duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY)

(duration) .... yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D.

, 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-25290