

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

23139
Do not use this space.

REC'D JUL 25 1938

1. PLACE OF DEATH
 (a) County Licking Registration District No. 868
 (b) Township Sherrill Primary Registration District No. 6149
 (c) City Licking (d) Street No. _____ Registered No. 23
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
 (If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME Trace David Freeland 6415
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 19, 1862
 7. AGE YEARS 75 MONTHS 8 DAYS 8 If LESS than 1 day, _____ hrs. or _____ min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Miller
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) May 19 38 11. Total time (years) spent in this occupation 16 yrs
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Herman MO
 13. NAME Trace D. Freeland
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Herman MO
 15. MAIDEN NAME Sofa Woodruff
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Herman MO
 17. INFORMANT (ADDRESS) Effie Freeland Licking
 18. BURIAL, CREMATION OR REMOVAL PLACE Licking Cem DATE 6-29-38
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm. Smith Ferguson Licking MO
 20. FILED 6/29 1938 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 27 1938
 22. I HEREBY CERTIFY That I attended deceased from June 27 1938 to June 27 1938
 I last saw him alive on June 27 1938. Death is said to have occurred on the date stated above, at 4:45 p.m.
 The principal cause of death and related causes of importance were as follows:
Chronic Nephritis
Endocarditis
 Date of onset _____
 Other contributory causes of importance: 131
 Name of operation none Date of _____
 What test confirmed diagnosis? chest Was there an autopsy? no
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no Date of injury 27, 19____
 Where did injury occur? Licking (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) Trace David Freeland; M. D.
 (Address) Licking MO

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,

Cubert Ferguson

or by

Registered Apprentice No., working under my personal supervision

Signed *Cubert Ferguson*

Licensed Embalmer No. *3945*

P. O. Address *Licking Ms*

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

23139
Do not use this space.

1. PLACE OF DEATH

(a) County Lea Registration District No. 868
 (b) Township Sherrell Primary Registration District No. 6149 Registered No. _____
 (c) City _____ (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Mace David Ireland
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 19 1862

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
70 8 8

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

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

FATHER 13. NAME
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE _____ 19.

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 6/29 1938 H. L. Reed Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 27 1938

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____

I last saw h. _____ alive on _____ 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____ 19____

Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify Leslie Randall, M. D.
 (Signed) _____

(Address) Licensing

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

Physicians should state EXACTLY. PHYSICIANS should state EXACTLY.

