S. No. 2
M—5-42
. 5-17-39
PI X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 20 1943

Registration District No. 149

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1602

State File No. 5173

Registrar's No. 705

48

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days (Specify whether years, months or days)
In this community 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson 3
(c) City or town: Kansas City 8
(If outside city or town limits, write "RURAL")
(d) Street No.: 7305 East 14th St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No): 0
If yes, name country:

3. (a) PRINT FULL NAME: Tom Freeman

3. (b) If veteran, name war: no

3. (c) Social Security No.: none

4. Sex: Male

5. Color or race: W.

6. (a) Single, widowed, married, divorced: Divorced 3

6. (b) Name of husband or wife: Unknown

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: Jan. (Month) 8, (Day) 1861 (Year)

8. AGE: Years 82 | Months 1 | Days 1 | If less than one day: hr. min.

9. Birthplace: Boone Co. (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation: farmer

11. Industry or business:

FATHER
12. Name: John Freeman
13. Birthplace: (City, town, or county) (State or foreign country) 9

MOTHER
14. Maiden name: Unknown
15. Birthplace: (City, town, or county) (State or foreign country) 9

16. (a) Informant: Mrs. Avery Connors
(b) Address: 7305 E. 14th.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-12-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Woodlawn

18. (a) Signature of funeral director: Rose & Henderson
(b) Address: K.C. Mo.

19. (a) 2-10-43 (Date received local registrar) (b) W. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 9th year 1943 hour 8:00 P.M. minute M.

21. I hereby certify that I attended the deceased from 1-2-43, 19..., to 2-9-43, 19...; that I last saw him alive on 2-9-43, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic pneumonia	
Due to: hypertrophied prostate	
Due to: 137a	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify):
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury:

23. Signature: Med. Dir. K.C. General Hospital (M.D. or other)
Address: Date signed

(Licensed Embalmer's Statement on Reverse Side)

FEB 25 1948

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed: G. E. Henderson

Licensed Embalmer No. 3657

P. O. Address K. 6. 2110

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, fact should be so stated above.

FILED FEB 2 1943

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. 705

City..... (No. ....., ... St. ..... Ward)

2. FULL NAME Tom 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
M	Wh	

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.
82			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.....

9. Industry or business in which work was done, as silk mill, 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. UNDERTAKER..... (ADDRESS)

20. FILED..... 19.... M. M. Brown
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) , 19

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:

Forwarded to Jeff. City. 2/19/43

137a

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.....

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

(Address).....

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

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