

No. 2
-1-4-41
5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

17994

State File No. _____

FILED JUN 12 1943

Registration District No. 140

Primary Registration District No. 5542

Registrar's No. 33

1. PLACE OF DEATH:

(a) County Howard
(b) City or town R. F. D. Higbee Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Perche Boone
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howard
(c) City or town R. F. D. Higbee Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May #11 day II
year 1943 hour 9 minute 25 a.m.

21. I hereby certify that I attended the deceased from 9 May 1943 to 9 May 1943
that I last saw him in alive on 9 May 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:
Of operations _____
Of autopsy _____
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? _____ (Specify type of place) _____ (Means of injury)
23. Signature [Signature] (M. D. or other)
Address _____ Date signed 5-12-43

3. (a) PRINT FULL NAME Frank. F. Friedadman

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: April 18 1872
(Month) (Day) (Year)

8. AGE: Years 71 Months 0 Days 23 If less than one day _____ hr. _____ min.

9. Birthplace Springfield Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER { 12. Name Joseph Friedadman

13. Birthplace Germany (City, town, or county) (State or foreign country)

14. Maiden name Inresea Voltz.

15. Birthplace Indiana (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Fred Blase
(b) Address Higbee Mo.

17. (a) Burial (b) Date thereof May 13 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Perche, Boone Co.

18. (a) Signature of funeral director Joe W. Burton

(b) Address Higbee Mo.

19. (a) 5-12-1943 (b) Emmett M. Waller
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 6-8-43.....

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 E. W. Friesmonth

Licensed Embalmer No. 3978

P. O. Address Glasgow 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 this body is not embalmed, fact should be so stated above.

Registration District No. 740

Primary Registration District No. 0-5-42

1. PLACE OF DEATH:

(a) County Howard
(b) City or town Rural Highlee
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Frank J. Freadman

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 18
(Month) (Day) (Year)

8. AGE: Years 71 Months _____ Days _____
If less than one day, _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____
(City, town, or county) (State or foreign country)

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 11
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw him alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature C.O. Enuchs (M.D. or other) D.O.

Address Highlee Mo. Date signed 1

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

5-17994