No. 2
9-4-41
5-17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

38954

State File No.

FILED DEC 14 1944

Registration District No.

Primary Registration District No. 3074

Registrar's No.

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sikeston
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Sikeston General Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard

(c) City or town Canalou 103
(If outside city or town limits, write "RURAL")

(d) Street No. ✓
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country ✓ 1

3. (a) PRINT FULL NAME Fannie Lee Freeman

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Female

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 Sept. (Month) 18 (Day) 1884 (Year)

8. AGE: Years 60 Months 2 Days 8 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Matt James
13. Birthplace Unknown (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 4 (State or foreign country)

16. (a) Informant Alvie Freeman
(b) Address Osceola Arkansas

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-44 (Month) (Day) (Year)
(c) Place: burial or cremation Wardell, Mo.

18. (a) Signature of funeral director Orville Taylor
(b) Address Sikeston, Mo.

19. (a) 12-7-44 (Date received local registrar) (b) Louie Largent (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 26 year 1944 hour 7 minute P.M.

21. I hereby certify that I attended the deceased from 11-1, 1944, to 11-26, 1944, that I last saw h. alive on 11-26, 1944, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary occlusion	1 Month
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death): Fract Hip ✓	1 Month

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 0

23. Signature C. M. Jones M.D. (M. D. or other)
Address Morehouse Mo. Date signed 11/29/44

1316

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No
District File Number 1244
Date Filed 12-13-44

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 Alfred W. Greer

Licensed Embalmer No. 1027

P. O. Address Poplar Bluff, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 333 Primary Registration District No. 3024 Registrar's No.

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sikeston
(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 Fannie L. Freeman

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

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 Sept (Month) 18 (Day) 1884 (Year)

8. AGE: Years 60 Months 2 Days 8 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

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

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month 12 day 26 year 1944 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 ; that I last saw h alive on 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Due to

Due to

Other conditions Fract Hip 1 Mon
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration
15 min

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) Accident

(b) Date of occurrence 10-25-44

(c) Where did injury occur? Home - Canalou New Madrid Mo (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 accident

23. Signature [illegible] M D (M. D. or other)

Address Morehouse Mo Date signed 12-16-44

SUPPLEMENTARY

Dr S M Sams M.D
Morehouse, Mo