

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

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Rural *Elk Camp*

(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 3 months years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stoddard

(c) City or town Canalou - Rural
(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 _____

3. (a) PRINT FULL NAME CHARLES F. FREEMAN

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month Nov day 8
year 1944 hour 2 minute 00 P. M.

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

6. (b) Name of husband or wife Fannie 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased Dec 24 (Month) (Day) (Year) 1885

21. I hereby certify that I attended the deceased from 10-20 to 11-8 1944 to 1944

that I last saw him alive on 10-20 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

8. AGE: Years 68 Months 10 Days 14 If less than one day hr. _____ min. _____

Due to _____

Due to _____

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

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

10. Usual occupation Farmer

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name Dave Know

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

14. Maiden name D.K.

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

16. (a) Informant Alva Freeman

(b) Address Canalou Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-44 (Month) (Day) (Year)

(c) Place: burial or cremation Wardell Mo

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? _____

18. (a) Signature of funeral director Welsh Funeral Home

(b) Address Sikeston Mo

19. (a) 4-22-45 (Date received local registrar) (b) Cardie Miller (Registrar's signature)

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

23. Signature J. L. Larns M.D. (M. D. or other)

Address Wardell, Mo Date signed 11-18-44

RECEIVED
District Health Office No. 2,
District File Number 545-685
Date Filed 5-7-45

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 Raymond Crews
Licensed Embalmer No. 3467
P. O. Address Liketon 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.