

S. No. 2  
 -12-45  
 -5-17-39  
 X47070

DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. **32768**  
 Registrar's No. **1153**

Registration District No. **42** Primary Registration District No. **1000**

1. PLACE OF DEATH:  
 (a) County Buchanan  
 (b) City or town St. Joseph  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
3023 Edmond St 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 In this community Lifetime (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Clinton 25  
 (c) City or town Hempfle R R 7  
 (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 JAMES FREEMAN  
 3. (b) If veteran, name war ✓  
 3. (c) Social Security No. ✓

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month October day 11  
 year 1946 hour 8 minute 30 P.M.  
 21. I hereby certify that I attended the deceased from Nov 10  
1930 to Oct 10 1946  
 that I last saw him alive on Oct 10 1946  
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Widowed  
 6. (c) Age of husband or wife if alive ✓ years  
 7. Birth date of deceased: March 10 1852  
 (Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_  
arterio Sclerosis ?  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

8. AGE: Years 94 Months 7 Days 10 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
 9. Birthplace Buchanan Co Mo (City, town, or county) (State or foreign country)  
 10. Usual occupation Farmer

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

MOTHER FATHER  
 11. Industry or business \_\_\_\_\_  
 12. Name Stephen Freeman  
 13. Birthplace unk unk (City, town, or county) (State or foreign country)  
 14. Maiden name Olga Kerns  
 15. Birthplace Dekalb Co Mo (City, town, or county) (State or foreign country)  
 16. (a) Informant James S. Freeman  
 (b) Address Hempfle Mo  
 17. (a) Burial (b) Date thereof Oct 13 1946  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation St. Ignace Chapel Cemetery  
 18. (a) Signature of funeral director [Signature]  
 (b) Address Stuartville Mo.  
 19. (a) Oct. 15, 1946 (b) [Signature]  
 (Date received local registrar) (Registrar's signature)

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 G. F. Timball M. D.  
 Address St. Joseph Mo R R 4 Date signed Oct 12-46

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

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(Licensed Embalmer's Statement on Reverse Side)

JAN 8 1944

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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 F. G. Ryan  
Licensed Embalmer No. 952  
P. O. Address Stuartville, 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.**