

7. S. No. 2  
 DOM-5-43  
 ev. 5-17-39  
 I X36671

**FILED JUN 9 1947**  
 1949

Registration District No. \_\_\_\_\_ Primary Registration District No. 1602

**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: General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 8 days  
(Specify whether years, months or days)  
 In this community 50 years

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2806 Troost  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Dorothea Helen Freed  
 3. (b) If veteran, name war No 3. (c) Social Security No. None  
 4. Sex Female / 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Gus A. Freed 6. (c) Age of husband or wife if alive 69 years  
 7. Birth date of deceased 1 21 1892  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month May day 25  
 year 1947 hour 12 minute 50 P.M.  
 21. I hereby certify that I attended the deceased from May 17 1947 to May 25 1947  
 that I last saw her alive on May 25 1947  
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>55</u>	<u>4</u>	<u>4</u>	hr. min.

Immediate cause of death Spontaneous cerebral hemorrhage  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions 830  
(Include pregnancy within 3 months of death)

9. Birthplace Pennsylvania  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Housewife  
 11. Industry or business \_\_\_\_\_  
 12. Name No Record  
 13. Birthplace No Record  
(City, town, or county) (State or foreign country)  
 14. Maiden name No Record  
 15. Birthplace No Record  
(City, town, or county) (State or foreign country)

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy See above  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

**MOTHER FATHER**  
 16. (a) Informant Mr. Gus A. Freed  
 (b) Address 2806 Troost  
 17. (a) Burial (b) Date thereof 5-28-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Mt. Washington  
 18. (a) Signature of funeral director Mrs. C.L. Forster  
 (b) Address Kansas City, Missouri  
 19. (a) 5-28-47 (b) Thalidine Holmes  
(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 Wm W. Hart (M. D. or other) MD  
 Address Med. Dir. Gen'l Hosp. Date signed 5-26-47

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

*Dr. Hibbard*

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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..... *Corland Munson* .....

..... Licensed Embalmer No. *3414* .....

P. O. Address..... *918 Broadway* .....

**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.**