

FILED NOV 10 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33233

State File No. 4675

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY Jackson

2. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission).
a. STATE Missouri b. COUNTY Jackson

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City

c. CITY OR TOWN Kansas City

c. LENGTH OF STAY (in this place) 3 years

d. FULL NAME OF HOSPITAL OR INSTITUTION Rest Home Johnson

f. STREET ADDRESS (If rural, give location) 2435 Prospect

3. NAME OF DECEASED (Type or Print) a. (First) GEORGE b. (Middle) H c. (Last) FREEMAN

4. DATE OF DEATH (Month) (Day) (Year) Oct. 27, 1955

5. SEX Male

6. COLOR OR RACE Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH April 29-1862

9. AGE (In years last birthday) 93

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter

10b. KIND OF BUSINESS OR INDUSTRY Laborer

11. BIRTHPLACE (City and State or Foreign Country) Lexington Mo.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Jefferson Freeman

13b. MOTHER'S MAIDEN NAME unknown

14. NAME OF HUSBAND OR WIFE _____

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO. _____

17. INFORMANT'S SIGNATURE OR NAME Mrs. Antine Brown 2127 1/2 Ave. K.C. Mo.
Carl Anderson Lexington Mo.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH Two days

*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Aortic Insufficiency

Three yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. DUE TO (c) _____

411 X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1952, to Oct 27, 1955, that I last saw the deceased alive on Oct 27, 1955, and that death occurred at 1:45 PM, from the causes and on the date stated above.

23a. SIGNATURE M. C. Lewis (Degree or title) Dr. C. Lewis, M.D.

23b. ADDRESS 210 Lincoln Bldg

23c. DATE SIGNED 10/28/55

24a. BURIAL CREMATION (REMOVAL) (Specify) Burial

24b. DATE 31 Oct 30 1955

24c. NAME OF CEMETERY OR CREMATORY Forest Green

24d. LOCATION (City, town, or county) Lexington Mo.

DATE REC'D BY LOCAL REG. 10-31-55

REGISTRAR'S SIGNATURE Neva Marshall

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS George H. Green Marshall Mo.

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

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
George Green

Licensed Embalmer No 42

P. O. Address *Marshall*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.