

58-006353

STATE FILE NUMBER

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED FEB 28 1958

Registration District No. 385

Primary Registration District No. 3039

Registrar's No. 300

1. PLACE OF DEATH a. COUNTY <u>Linn</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marion</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Zinn Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST FRANCIS HOSP</u>			Length of stay in lb <u>21 days</u>		d. STREET ADDRESS (If outside, give location) <u>4201</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Maudie Freeland</u>				4. DATE OF DEATH Month Day Year <u>Feb. 15-1958</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 5-1891</u>		9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Min. <u>86 2 4</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (City and state or country) <u>Sullivan Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Henry R. Warren</u>			13b. MOTHER'S MAIDEN NAME <u>Corline Mc. Pheeters</u>		14. NAME OF HUSBAND OR WIFE <u>Daniel G. Freeland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Daniel G. Freeland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism + thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Emboli secondary to coronary thrombosis with arrhythmic fibrillation</u>						<u>2 weeks</u>		
DUE TO (c) <u>Arteriosclerosis</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>4201</u>					
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE		
21. I attended the deceased from <u>1-31-58</u> to <u>2-15-58</u> and last saw her alive on <u>2-15-58</u> Death occurred at <u>6:30 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Dr or title) <u>Arthur R. Dyer M.D.</u>			22b. ADDRESS <u>Burnfield, Mo</u>			22c. DATE SIGNED <u>2-17-58</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <u>Schrock</u>		23d. LOCATION (City, town, or county) (State) <u>Sullivan Co. Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>J. H. Brothers Zinn Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>2-20-58</u>		26. REGISTRAR'S SIGNATURE <u>Brookie Owens</u>			

(Licensed Embalmer's Statement on Reverse Side)

Health,
Welfare
Public
Service300
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms write by instance. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *Blake Glidden*

Licensed Embalmer No. *5019*
P. O. Address *Sacred*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.