

# WASHINGTON STATE BOARD OF HEALTH

Record No. 69

## BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

PLACE OF DEATH  
County of Okanogan  
City or Town of Russell

File No. \_\_\_\_\_  
Registered No. 1  
St.: \_\_\_\_\_ Ward \_\_\_\_\_

If death occurs away from  
USUAL RESIDENCE give  
facts called for under "Special  
Information."

Registration Dist. No. \_\_\_\_\_ (No. \_\_\_\_\_)  
Full Name Albert E Freeman 656

[If death occurred in a  
Hospital or Institution give  
its NAME instead of street  
and number.]

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>M</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>M</u> <small>(Write the word)</small>
6 DATE OF BIRTH <u>June 7, 1868</u> <small>(Month) (Day) (Year)</small>		
7 AGE <u>50</u> yrs. <u>2</u> mos. <u>22</u> ds. <small>If LESS than 1 day, _____ hrs. or _____ min. ?</small>		
8 OCCUPATION <small>(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer)</small> <u>Farmer</u>		
9 BIRTHPLACE <small>(State or country)</small> <u>Iowa</u>		
PARENTS	10 NAME OF FATHER <u>Geo Freeman</u>	
	11 BIRTHPLACE OF FATHER <small>(State or country)</small> <u>O.</u>	
	12 MAIDEN NAME OF MOTHER <u>Maria Pease</u>	
	13 BIRTHPLACE OF MOTHER <small>(State or country)</small> <u>O.</u>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) \_\_\_\_\_  
(Address) \_\_\_\_\_  
15 Filed 8/30 1918 REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 29, 1918  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 3, 1918, to Aug 28, 1918, that I last saw him alive on Aug 26, 1918, and that death occurred, on the date stated above, at 10:20 a.m.  
The CAUSE OF DEATH\* was as follows:  
Organic shock due to  
MI  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) W M Taylor M. D.  
8/29 1918 (Address) Russell

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) \_\_\_\_\_ In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted, if not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL <u>Russell Cemetery</u>	DATE OF BURIAL <u>8/30</u> 191 <u>8</u>
20 UNDERTAKER <u>None</u>	ADDRESS _____

### Revised Standard Certificate of Death

Approved by U. S. Census and American Public Health Association.]

Precise statement

Examples: Cerebrospinal fever (the disease); Epidemic cerebro-spinal meningitis; Diphtheria (avoid use of "Typhoid fever" never report "Typhoid pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meningis, peritoneum, etc. Carcinoma, Sarcoma, etc., of... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Ovary, uterine

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.