N. B.—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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Pemiscott

Township: ~~Little Prairie~~

or Village:

or City: Cornhersville Mo (NO. ____ St.; ____ Ward)

Registration District No. 651 File No. 19647

Primary Registration District No. H388 Registered No. 85

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME: Wayne Franklin

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: June (Month) 4 (Day), 1914 (Year)

AGE: one yrs. ____ mos. 23 ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

BIRTHPLACE (City or town, State or foreign country): Pemiscott Co

PARENTS

NAME OF FATHER: Roy Franklin

BIRTHPLACE OF FATHER (City or town, State or foreign country): Tenn

MAIDEN NAME OF MOTHER: Fannie Mayfield

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Cora Mayfield

(ADDRESS): Cornhersville Mo

Filed 6/27, 1915 B D Crane REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: June (Month) 27 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from June 25, 1915, to June 27, 1915; that I last saw him alive on June 26, 1915; and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

119 B 104

(Duration) ____ yrs. ____ mos. 6 ds.

Contributory (SECONDARY) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) C E Martin M. D.

6 27 1915 (Address) Cornhersville Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL: Cornhersville

DATE OF BURIAL: 6/27, 1915

UNDERTAKER: J R Lewis

ADDRESS: Cville

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

N. B.—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.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... (Month) ..... (Day), *1*..... (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., *191*.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,

that I last saw h.....alive on ....., 191.....,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory .....
(SECONDARY)

.....(Duration).....yrs. .....mos. .....ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS