LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

5234

EB 25 1927

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

PLACE OF DEATH
County Knox
Township Salt River
City Novelty (No. ..... St. ..... Ward)

Registration District No. 446
Primary Registration District No. 5606
File No. .....
Registered No. .....

FULL NAME August William Fredrick Franke

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
ale	White	Married

~~If Married, Widowed, or Divorced~~
HUSBAND OF ~~(OR) WIFE OF~~ Mrs August W. F. Franke

DATE OF BIRTH (MONTH, DAY AND YEAR) March 4 1882

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	44	11	0	

OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer) General.
(c) Name of employer

BIRTHPLACE (CITY OR TOWN) Yorin
(STATE OR COUNTRY) Scotland County

10. NAME OF FATHER August Franke

11. BIRTHPLACE OF FATHER (CITY OR TOWN) unk
(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Christian Hoyer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) unk
(STATE OR COUNTRY) Germany

INFORMANT Mrs A. B. Cowles
(Address) Novelty Mo.

FILED Feb 9th 1927 L. F. Bryan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

4

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 4 1927

17. I HEREBY CERTIFY, That I attended deceased from Jan. 6, 1927, to Feb. 4, 1927 that I last saw him alive on Feb. 4, 1927, and that death occurred, on the date stated above, at 10 15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Measles
(duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (SECONDARY) Bronchopneumonia, abscess + Gangrene of lungs (duration) ..... yrs. ..... mos. 27 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) W. L. Landfather, M.D.
, 19 (Address) Novelty, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Novelty Cemetery	Feb 8 1927
20. UNDERTAKER	ADDRESS
Brothers & Innings	Novelty Mo

V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No.....) ..... St. .....Ward

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. d

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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.....

.....

.....

.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.

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