1 PLACE OF DEATH

County Oregon

Township Myrtle

Inc. Town or City ____ (No. ____, ____ St.; ____ Ward)

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

31087

Registration District No. 635

File No. 32

Primary Registration District No. 6279

Registered No. 32

2 FULL NAME H. Lloyd Franklin

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

(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. ____ da. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR or RACE: Wht.

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH: 10 (Month) 19 (Day), 1927 (Year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		10	

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) Myrtle Mo.
(State or country)

PARENTS

10 NAME OF FATHER Sam T. Hall

11 BIRTHPLACE OF FATHER (city or town) Atlanta, Georgia
(State or country)

12 MAIDEN NAME OF MOTHER Anna Regina

13 BIRTHPLACE OF MOTHER (city or town) Knoxville,
(State or country) Tenn.

14 Informant Sam T. Hall
(Address) Myrtle

15 Filed 11-3, 1927 H. Wallace Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 10 (Month) 29 (Day), 1927 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 19, 1927, to Oct. 29, 1927 that I last saw him alive on Oct. 28th, 1927 and that death occurred, on the date stated above, at 12 a.m.

The CAUSE OF DEATH* was as follows:
Spina Bifida
157 B
79 A (duration) ____ yrs. ____ mos. 10 da.

CONTRIBUTORY (Secondary) Meningitis
____ (duration) ____ yrs. ____ mos. ____ da.

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

Did an operation precede death? No Date of ____

What operation performed? None

Was there an autopsy? None

What test confirmed diagnosis? ____

(Signed) Rev. W. R. Phillips M. D.

11-2 1927 (Address) Myrtle, Mo.

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (3) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, or REMOVAL: Myrtle — DATE OF BURIAL: 10-30 1927

20 UNDERTAKER: A. Hackworth — ADDRESS: Myrtle, Mo.

Burial or Transit Permit issued by ____ Date of Issue ____

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. 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.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired*, 6 *yrs.*). For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. *The contributory* (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMOCIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Note.—Certificates may be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.