

No. H.—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

Do not use this space.

17055

File No. _____
 Registered No. _____
 _____ St. _____ Ward)

1. PLACE OF DEATH

County Randolph
 Township Salt Spring
 City _____ (No. _____)

Registration District No. 933
 Primary Registration District No. 5967

2. FULL NAME Thelma Beatrice Green

(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

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 3rd 1903

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	26	6	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Macon Co
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Oscar M. Franklin

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

12. MAIDEN NAME OF MOTHER Ida Crowder

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

14. INFORMANT Oscar M. Franklin
 (Address) Huntsville Mo.

15. FILED _____ 19 _____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 6 19 30

17. I HEREBY CERTIFY, That I attended deceased from Sept 1928 to May 6 1930 that I last saw her alive on Friday, May 4, 1930, and that death occurred, on the date stated above, at 12 o'clock m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Tuberculosis of lung
23A

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) D. B. Barnhart, M. D.

, 19 (Address) Huntsville 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Hebron Cem. DATE OF BURIAL 5/8 19 30

20. UNDERTAKER Stephens & Gooding ADDRESS Macon Mo.

10-10-68

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Randolph
Township Salt Spring
City No. St. Ward

Registration District No. 433
Primary Registration District No. 9-967

File No.
Registered No. 16
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. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 3rd 1903

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>26</u>	<u>6</u>	<u>3</u>	

8. OCCUPATION OF DECEASED.

(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

10. NAME OF FATHER Oscar M. Franklin

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT Oscar M. Franklin
(Address) Huntsville Mo

15. July 10, 1930 H G Bray
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 6 1930

17. I HEREBY CERTIFY That I attended deceased from Sept 1929 to May 6 1930 that I last saw him alive on May 4 1930, and that death occurred, on the date stated above, at 12 4 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis of lungs

CONTRIBUTORY (SECONDARY) (duration) 3 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH. DATE OF

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Hebron Cem.

DATE OF BURIAL 3/8 1930

20. UNDERTAKER Stephens & Lording
(Address) Huntsville 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.

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-17055