SEP 24 1930

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

Do not use this space.

26268

1. PLACE OF DEATH
County Dallas
Township S Benton
City Buffalo (No. ..., ... St. ..... Ward)

Registration District No. 241
Primary Registration District No. 4147

File No. .....
Registered No. 3 [illegible]

2. FULL NAME Frank Fall

(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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Unknown

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

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

7. AGE: 81 YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: In mate
(b) General nature of industry, business, or establishment in which employed (or employer): of County Farm
(c) Name of employer

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

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown

14. INFORMANT (Address): Jeff Atwater, Buffalo

15. FILED 8/10, 1930 Harvey Moore, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Aug-8 19

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930, to ....., 19..., that I last saw him alive on Aug 1, 1930, and that death occurred, on the date stated above, at 1230a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Rectum

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (SECONDARY) 45

(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) C. O. Hammon, M. D

, 19 (Address)

*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: Reynolds Chapel
DATE OF BURIAL: Aug-8-30

20. UNDERTAKER: L B Jones
ADDRESS: Buffalo Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.