

DEC 20 1930

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

Do not use this space.

1. PLACE OF DEATH  
 County Buchanan Registration District No. 85  
 Township \_\_\_\_\_ Primary Registration District No. 1001  
 City St. Joseph Mo., (No. 2015 Sylvania St) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME  
George Grant Franklin

(a) Residence No. 2015 Sylvania 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.

File No. 35401  
Registered No. 2223

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 8 1871

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
59 8 29

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

9. BIRTHPLACE (CITY OR TOWN) Carthage Mo.,  
 (STATE OR COUNTRY)

10. NAME OF FATHER William Franklin

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

12. MAIDEN NAME OF MOTHER Susan Franklin

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

14. INFORMANT Mrs Emma Franklin (Wife)  
 (Address) 2015 Sylvania St

15. FILED 12 1930  
John S. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 7 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov 7 1930 to Nov 7 1930  
 that I last saw him alive on Nov 7 1930 and that death occurred, on the date stated above, at 12:30 P.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Angina Pectoris  
Chronic Adhesion  
Pericarditis (duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chronic Adhesion  
Pericarditis (duration) 2 yrs. mos. 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? none  
 (Signed) J. D. Peyton M. D.  
11/3 1930 (Address) St. Joseph 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 City Cemetery DATE OF BURIAL 11-14 1930

20. UNDERTAKER B.F. Graves ADDRESS 806 S 17th

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.

