FEB 27 1934

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

Do not use this space.

Gronoway

1. PLACE OF DEATH
County Macon — Registration District No. 533 — File No. 1847
Township Hudson — Primary Registration District No. 3027 — Registered No. 7
City Macon (No. , St. Ward)

2. FULL NAME Ben Franklin
(a) Residence, No. St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)
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): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR) WIFE OF~~ Grace M. Franklin

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 14 1861

7. AGE: YEARS 72 — MONTHS 4 — DAYS 3 — If LESS than 1 day, hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Lawyer
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Putnam Co, Mo

FATHER
13. NAME John Nelson Franklin
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Highland Co, Ohio

MOTHER
15. MAIDEN NAME Sarah E. Lucas
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) W. Virginia

17. INFORMANT (ADDRESS) John Franklin Macon, Mo

18. BURIAL, ~~CREMATION, OR REMOVAL~~ PLACE Oakwood Cem, Macon DATE Jan 19 1934

19. UNDERTAKER (ADDRESS) Albert Skinner Macon Mo

20. FILED , 19 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 17 1934

22. I HEREBY CERTIFY, That I attended deceased from Jan 9, 1934, to Jan 17, 1934
I last saw him alive on Jan 17, 1934. Death is said to have occurred on the date stated above, at 5:30 A.m.
The principal cause of death and related causes of importance were as follows:

Traumatic peritonitis due to a fall with leakage from injury to caecum. — Date of onset 12

Other contributory causes of importance:

Name of operation High Jejunostomy Laboratory Date of Jan 16-34
What test confirmed diagnosis? autopsy Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? accident Date of injury Jan 6, 1934
Where did injury occur? at his home Macon (Specify city or town, county, and State) MO
Specify whether injury occurred in industry, in home, or in public place. Home
Manner of injury A fall on brick pavement
Nature of injury Contusion of abdomen

24. Was disease or injury in any way related to occupation of deceased? NO
If so, specify
(Signed) J. P. Gronoway M.D.
(Address) Macon Mo

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

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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON 1847 -

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

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ear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make very effort to obtain the following information, indicated by check marks, lacking rom the death certificate.

ame: Ben Franklin

no died at _____ on Jan. 17 - 1934

esidence: No. _____ St. _____
(If nonresident, city or town)

ength of residence in city or
own where death occurred: Years _____ Months _____ Days _____

ex _____ Color or race _____ Single, married, widowed or divorced: _____

ate of birth _____ Age: Years _____ Months _____ Days _____

ccupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

ate deceased last worked at this occupation: Month _____ Year _____

irthplace (State or country) _____

irthplace of father (State or country) _____

irthplace of mother (State or country) _____

rincipal cause of death: _____

ther contributory causes of importance _____

ame of operation _____ Date of _____

hat test confirmed diagnosis? _____ Was there an autopsy? _____

f death was due to external causes (violence) fill in also the following:

ccident, suicide, or homicide? _____ Date of injury _____, 19 _____

here did injury occur? _____
(Specify city or town, county and State)

pecify whether injury occurred in industry, in home, or in public place.

anner of injury _____

ature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar (Feb 10th 1934 Love Cross) Date filed

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

Reg. Dist. No. 533

Primary Reg. Dist. No. 3027

E. T. McGaugh
Special Agent. M. D.

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