

AUG 27 1937

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

Do not use this space.

28032

1. PLACE OF DEATH

County Cass Registration District No. 658
Township Saline Primary Registration District No. 65870
City (No. _____) St. _____ Ward _____

2. FULL NAME

C. Franklin Difani
(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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Bele Manning</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Dec. 7, 1862</u>		
7. AGE	YEARS <u>74</u>	MONTHS <u>7</u>
	DAYS <u>24</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, Sawyer, bookkeeper, etc. <u>Farmer</u>	
	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)
Cass Co Mo,13. NAME
Joseph Difani14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
Baden Germany15. MAIDEN NAME
Matilda Littell16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
Germany17. INFORMANT (ADDRESS)
Claude Difani
Truquille Route 718. BURIAL, CREMATION, OR REMOVAL
PLACE St. Marys Cem DATE Aug 2 193719. UNDERTAKER (ADDRESS)
Bob Lind, Gt
Truquille Mo20. FILED 8/2 1937 St. Marys Registrar
H. F. Sivabb.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-1 193722. I HEREBY CERTIFY, That I attended deceased from 7-14 to 8-1I last saw 17 alive on 7-14 1937. Death is saidto have occurred on the date stated above, at 5:30 AM.

The principal cause of death and related causes of importance were as follows:

Left Lung abscess
Chronic Myocarditis
Diabetes Mellitus
Supp

Other contributory causes of importance: GA

Name of operation _____ Date of _____

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

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

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

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

Manner of injury _____

Nature of injury _____

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

If so, specify _____

(Signed) Osvald Carr, M. D.(Address) Perryville, Mo.

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.

65

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

28037

Do not use this space.

1. PLACE OF DEATH

(a) County Jerry Registration District No. 658
 (b) Township Saline Primary Registration District No. 3875 Registered No.
 (c) City (d) Street No. St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME C. Franklin Difoni

(a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
74 7 24

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as 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)

FATHER 13. NAME
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
 PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 8-2 1937 F. Groff Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-1 1937

22. I HEREBY CERTIFY, That I attended deceased from to 19.....

I last saw h. alive on 19..... Death is said to have occurred on the date stated above, at m.
 The principal cause of death and related causes of importance were as follows:

left lung abscess
I don't know the cause but said to be no tuberculosis
 Other contributory causes of importance:

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19.....
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify (Signed) Oscar A. Carron, M. D.
 (Address) Jerryville Mo

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 COMPLETED AS PRESCRIBED BY LAW.

S-28032