REC'D MAR 16 1939

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

Do not use this space.

7008

1. PLACE OF DEATH
County: Lafayette
Township: Dover
City: ..... (No. ..... St. ..... Ward)

Registration District No. 460
Primary Registration District No. 5623

File No. .....
Registered No. 7

2. FULL NAME 652 Barbra Ellen Franklin

(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: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 1 - 1938

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	1	11	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. —
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 0

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dover, Mo 0

FATHER

13. NAME Cecil H. Franklin 0
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hodge, Mo

MOTHER

15. MAIDEN NAME Mary Alice Willard
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lexington, Mo

17. INFORMANT Cecil H. Franklin
(ADDRESS) Dover, Mo

18. BURIAL, ~~CREMATION, OR REMOVAL~~
PLACE Dover, Mo DATE Jan 13 1939

19. UNDERTAKER Winkler
(ADDRESS) Lexington, Mo

20. FILED Feb 10 1939 Tiffany Webb
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 12, 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 12, 1939, to Jan 12, 1939
I last saw him alive on Jan 13, 1939. Death is said to have occurred on the date stated above, at 10:30 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Bronchial Pneumonia	

Other contributory causes of importance:
none

Name of operation — Date of —
What test confirmed diagnosis? none Was there an autopsy? no

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? no
If so, specify .....
(Signed) B. E. Brashear, M. D.
413 (Address) Lexington, 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 importa

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed: 3/3/39

1092

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

7008
Do not use this space.

1. PLACE OF DEATH
(a) County Lafayette Registration District No. 460
(b) Township Dover Primary Registration District No. 3623 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 Barbra Olive Franklin
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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.
	1	11	

OCCUPATION
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 19 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1 - 12 1930

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

	Date of onset
Broncho Pneumonia	
NO	1 D

Other contributory causes of importance:
No Contributory

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) B. H. Brasher, M. D.
(Address) Lexington 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.

NO CERTIFICATE SHALL BE ISSUED UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Public Health Records

COMPLETED

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