

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

40821

State File No. \_\_\_\_\_

REG 9 784  
Registration District No. 784

Primary Registration District No. 200

Registrar's No. 2027

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Overland

(c) Name of hospital or institution 9527-Marlowe Ave. 2  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 25 years  
(Specify whether years, months or days)

In this community 25 years

3. (a) PRINT FULL NAME Philip B. Franer

3. (b) If veteran, name war

3. (c) Social Security No. 6516

4. Sex 7 5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife James W. Franer

6. (c) Age of husband or wife if alive 26 years

7. Birth date of deceased Oct. 26 1864  
(Month) (Day) (Year)

8. AGE: Years 75 Months 0 Days 22 If less than one day \_\_\_\_\_ min.

9. Birthplace Murphysboro, Tenn.  
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business None

MOTHER FATHER

12. Name Frank Chelt. Franer

13. Birthplace Murphysboro Tenn.  
(City, town, or county) (State or foreign country)

14. Maiden name Miss Miller

15. Birthplace Adot Springs Ark.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature William J. Franer

(b) Address 9527-Marlowe Overland Mo.

17. (a) Bemoral (b) Date thereof 11-22-39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Adot Springs Ark.

18. (a) Signature of funeral director James J. Franer

(b) Address 204 Woodmont - Overland Mo.

19. (a) NOV 20 1939 (Date received local registrar)

(b) W. J. Franer (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Overland  
(If outside city or town limits, write "RURAL")

(d) Street No. 9527-Marlowe Ave.  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 17  
year 1939 hour 10 minute 55 P. M.

21. I hereby certify that I attended the deceased from Sept 20, 1939, to Nov 17, 1939.

that I last saw her alive on Nov 17, 1939, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy

Duration 10 days

Due to Hypertensive vascular disease 3-4 yrs?

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: J 2 a

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(a) Means of injury \_\_\_\_\_

23. Signature D. B. Michael (M. D. or other) 1939

Address 506 Olive Date signed 11/20/39

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Escar F. Mueller

Licensed Embalmer No. 3039

P. O. Address Overland Mo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**