

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

1. PLACE OF DEATH:

(a) County Henry

(b) City or town Windsor
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

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

In this community 25 years

3. (a) PRINT FULL NAME Charles B. Franklin 1652

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Ida Brooks Franklin 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 8 1865
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

74 9 8 _____ hr. _____ min.

9. Birthplace Green Ridge Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farming (Retired)

11. Industry or business _____

MOTHER FATHER { 12. Name Silas Franklin

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

MOTHER FATHER { 14. Maiden name Elizabeth Powell

15. Birthplace unknown unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Mabel Richards

(b) Address Sedalia, Mo.

17. (a) Burial (b) Date thereof May 18-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Windsor, Mo

18. (a) Signature of funeral director Huston-Turner 310

(b) Address Windsor, Missouri 310

19. (a) 5-17-40 (b) T. J. Johnson 50
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry

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

(d) Street No. 507 W. Colt Street
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16
year 1940 hour 9:30 a m minute _____ M.

21. I hereby certify that I attended the deceased from May 6 1940 to May 16 1940
that I last saw him alive on May 9 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Heber Pneumonia Duration 10

Due to _____

Due to _____

Other conditions Influenza 2 used
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Major findings: _____
Of operations _____

Of autopsy _____

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)

(e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address [Address] Date signed 5-17-40

RECEIVED
District Health Officer No. 7
District File Number 6-40-889
Date Filed 6-18-40

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 Edw. M. Fuston
Licensed Embalmer No. 3391
P. O. Address Wardner, 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.