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FILED JUL 15 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21731

Registration District No. 318 Primary Registration District No. 2001 Registrar's No. 504

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2150 East Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ In this community 652 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 2150 East Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME JOSEPH SHELBIA FRANKLIN
3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Mary Dona Franklin
6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased Dec. 6 1875 (Month) (Day) (Year)

8. AGE: Years 64 Months 6 Days 0 If less than one day ____ hr. ____ min.

9. Birthplace Unknown (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Retired
11. Industry or business In Store Room (R.R.)
FATHER
12. Name James Cook Franklin
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Pauline Jane Dollison
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. M. J. Williams
(b) Address Springfield. Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 7 1940 (Month) (Day) (Year)
(c) Place: burial or cremation East Lawn Cem.
18. (a) Signature of funeral director J. H. Klingner
(b) Address Springfield. Mo.
19. (a) June 7 1940 (Date received local registrar) (b) W. E. Handley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6 year 1940 hour 2 minute 00 A. M.
21. I hereby certify that I attended the deceased from 4/10/40 ~~4/10~~ 1940 to 6-6 1940 that I last saw him alive on 6/6 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cancer of Stomach primary	
Due to Malignancy	
Due to Involving Duodenum	
Other conditions — (Include pregnancy within 3 months of death)	
Major findings: Of operations none	46
Of autopsy no	

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? none (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? no (Specify type of place)
While at work? no (e) Means of injury —
23. Signature J. F. Freeman (M. D. or other)
Address Springfield Mo. Date signed 7/6/40

(Licensed Embalmer's Statement on Reverse Side)

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

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 Mrs Catherine Flingn

Licensed Embalmer No. 3719

P. O. Address Springfield M

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

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