No. 2
-13-40
17-39
X23

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 10 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31559

Registration District No. 104 Primary Registration District No. 3058 Registrar's No. 233

1. PLACE OF DEATH:
(a) County: CALLAWAY
(b) City or town: FULTON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: MISSOURI HOSPITAL No. 1 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 yrs. - 7 mos. - 8 days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Cole
(c) City or town: Jefferson City
(If outside city or town limits, write "RURAL") 0
(d) Street No.: 637 E. Capitol Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: FRANK T. QUINN
3. (b) If veteran, name war:
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: MRS. RUBY QUINN
6. (c) Age of husband or wife if alive: D.K. years
7. Birth date of deceased: D.K. (Month) D.K. (Day) 1884(?) (Year)
8. AGE: Years 56 Months D.K. Days D.K. If less than one day ____ hr. ____ min.
9. Birthplace: Keokuk - Iowa 1
(City, town, or county) (State or foreign country)
10. Usual occupation: Sales Work 9
11. Industry or business: D.K.
MOTHER FATHER
12. Name: D.K. 9
13. Birthplace: (City, town, or county) (State or foreign country)
14. Maiden name: D.K.
15. Birthplace: (City, town, or county) (State or foreign country)
16. (a) Informant: Hospital Record
(b) Address: Missouri Hospital #1 - Fulton, Mo
17. (a) Buried (Burial, cremation, or removal) (b) Date thereof: Sept 17 1940 (Month) (Day) (Year)
(c) Place: burial or cremation: National Cemetery Jeff. City
18. (a) Signature of funeral director: James Sevier
(b) Address: Top Jefferson - Jefferson City, Mo
19. (a) 9/15/40 (Date received local registrar) (b) R. M. Crews (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 15th year 1940 hour 11 minute 55 A.M.
21. I hereby certify that I attended the deceased from September 15, 1940, to September 15, 1940, that I last saw him alive on September 15, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Spontaneous Rupture of Bladder	4 hours
Due to Ulcerative Cystitis	D.K.
Due to Prostatic Hypertrophy	Chronic
Other conditions (Include pregnancy within 3 months of death) Chronic Myocarditis	Chronic
General Paralysis of Insane	Chronic

Major findings:
Of operations: None
Of autopsy: Spontaneous Rupture of Bladder etc.

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? No
While at work? (Specify type of place) (e) Means of injury
23. Signature: George E. Moore (M. D.)
Address: Fulton - 1020. Date signed: 9-15-40

(Licensed Embalmer's Statement on Reverse Side)

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 F. H. Anderson

Licensed Embalmer No. 3641

P. O. Address Jefferson City

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

If this body is not embalmed, fact should be so stated above.