

No. 2
4-13-40
-17-39
X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **17231**
1893
Registrar's No. _____

Registration District No. 399 Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: Research Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 50 years
In this community 50 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Peter H. Franke
3. (b) If veteran, name war Yes
3. (c) Social Security No. 486-10-2785

4. Sex Male 5. Color or race white
6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 11, 1891
(Month) (Day) (Year)

8. AGE: Years 50 Months 0 Days 3
If less than one day hr. _____ min. _____

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

10. Usual occupation Insurance Claims Attorney

11. Industry or business T. H. Mastin & Company

12. Name August H. Franke

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

14. Maiden name Dora Reinhardt

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

16. (a) Informant Mrs. Dora Franke
(b) Address 4100 Prospect Avenue

17. (a) Burial (b) Date thereof May 16, 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood
Freeman Mortuary
(d) Address 104 West 42nd Street

19. (a) May 14, 41 (b) M. M. Craze
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 4100 Prospect Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 14th
year 1941 hour 9 minute 30 a.m.

21. I hereby certify that I attended the deceased from Apr 12, 1941, to May 14, 1941;
that I last saw him alive on May 14, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death probable encephalitis
(Autopsy report to follow)
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy not determined - no gross findings.

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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature Samuel Adams (M. D. or other) _____
Address 820 Prof Bldg Date signed 5/14/41

Duration 3 weeks
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

80 B

Dr. Robt. Davis
Prof Bldg.
#2892
2:00 to 4:00

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 Clarence Chiles

Licensed Embalmer No. 3473

P. O. Address Ke 160

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **17231**

Registrar's No. **1893**

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(c) Name of hospital or institution:
Research Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days)

3. (a) PRINT FULL NAME *Peter H. Franke*

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

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

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years *50* Months Days If less than one day..... hr..... min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (d) Signature of funeral director.....

(b) Address.....

19. (a) *5/4/41* (b) *M. M. Browne*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town.....
(If outside city or town limits write "RURAL")
(d) Street No. *4100 Prospect*
(If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

20. DATE OF DEATH.....

Month *May* day *14*
year *1941* hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....

that I last saw h..... alive on..... 19..... and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to *acute nephritis*

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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 *Acute Nephritis* (M. D. or other).....
Address *870 prof Bldg* Date signed.....

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

SUPPLEMENTAL

Duration

*3 wks
7 wks*

PHYSICIAN

Underline the cause to which death should be charged statistically.

ROBERT C. DAVIS, M. D.
R. C. McCLANAHAN, M. D.
. 820 PROFESSIONAL BLDG.
KANSAS CITY, MISSOURI

Pasteron

June 17, 1941

Bureau of Vital Statistics
Health Department
Kansas City, Missouri

Re: Peter H. Franke, Deceased

Gentlemen:

We are enclosing the supplementary death certificate as requested by you.

The autopsy was at last completed, and from the autopsy report, he had an encephalitis and also an unusual type of nephritis, the cause of which is difficult to state, as there were some crystals in the kidney which we have not been able to identify, and which were not due to sulphathiazole.

We feel that the death certificate should go through at present as signed, because even after the autopsy, we do not know much about this man.

I am sorry there has been such a long delay in getting this settled, and wish to thank you for your consideration.

Very truly yours,

Drs. Davis and McClanahan

Robert C. Davis
Robert C. Davis, M.D.

RCD/eb