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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 15 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **30396**
Registrar's No. **7735**

Registration District No. **791** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 mo. 18 days
In this community 18 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis, 25
(If outside city or town limits, write "RURAL")
(d) Street No. 1329 Blair
(If rural, give location) _____
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 24, 1941
year _____ hour _____ minute 50 A. M.
21. I hereby certify that I attended the deceased from July 6, 1941
to September 24, 1941
that I last saw him alive on September 24, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death: Prob Carcinoma of Prostate Duration Prob 15 yrs

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

Major findings: _____
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) _____
(e) Means of injury _____
23. Signature J. W. Johnson (M. D. or other) _____
Address 2601 N Whittier Date signed 9-24-41

3. (a) PRINT FULL NAME Joe Franklin

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Nellie Franklin 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased Jan 10 1892
(Month) (Day) (Year)

8. AGE: Years 49 Months 8 Days 14 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Nellie Franklin

(b) Address 1329 Blair

17. (a) Burial (b) Date thereof 9-27-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director J. H. Green
(b) Address 2915 Franklin

19. (a) SEP 25 1941 (b) J. B. Decker
(Date received local registrar) (Registrar's signature)

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

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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.....

G. A. Green

Licensed Embalmer No. *2963*

P. O. Address *2915 Franklin*

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.