

1-4-41
5-17-39
I X26390

Registration District No. **255**

Primary Registration District No. **5872**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Oregon
(b) City or town Rover mo
(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
In this community 75 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Oregon
(c) City or town Rover
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 25
year 1942 hour 11 minute 30 M.

21. I hereby certify that I attended the deceased from Dec. 5 1941 to Feb. 25 1942
that I last saw him alive on Feb. 8 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma Prostate glands and bladder.

Due to Ch. Prostatitis

Due to _____

Other conditions (Include pregnancy within 3 months of death) 518

Major findings: Of operations NONE

Of autopsy NONE

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 Arthur H. Huxford (M. D. or other) M. D.
Address West Plains, Missouri Date signed 3/11/42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Ch. Frank Traubham

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

4. Sex mo 5. Color or race W 6. (a) Single, widowed, married, divorced W2

6. (b) Name of husband or wife Mauida Traubham 7. (c) Age of husband or wife if _____ years

7. Birth date of deceased 10-25-1863 (Month) (Day) (Year)

8. AGE: Years 78 Months 4 Days _____ If less than one day hr. min.

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

10. Usual occupation farmer

11. Industry or business _____

12. Name Ch. Traubham

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

14. Maiden name Kasuma Batty

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

16. (a) Informant Add Traubham

(b) Address Rover mo

17. (a) B (b) Date thereof 2-27-42 (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Arthur H. Huxford

(b) Address West Plains mo

19. (a) 3-16-42 (Date received local registrar) (b) _____ (Registrar's signature)

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

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1113

Sharburg W

RECEIVED

District Health Officer No. 5;

District File Number 742576

Date Filed 8-14-42

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: *Karw D. Roberts*

Licensed Embalmer No. 34307

P. O. Address: *West Haven*

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.

STANDARD CERTIFICATE OF DEATH

State File No. 24923

Registration District No. 255

Primary Registration District No. 5872

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Oregon
(b) City or town Rainier
(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
In this community 75 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Oregon
(c) City or town Rainier
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Eli Jno Frankham
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct. 25 1868
(Month) (Day) (Year)

8. AGE: Years 78 Months 4 Days _____ If less than one day _____ min.
9. Birthplace Deer Creek, Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Eli Frankham

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

14. Maiden name Roseanna Baly

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

16. (a) Informant add Frankham
(b) Address Rainier, Mo

17. (a) B (b) Date thereof 2-27-42
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director J. J. [unclear]
(b) Address West Plains, Mo

19. (a) 3-16-42 (b) Lucy M. Nelson
(Date reported local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ live on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of prostate gland and bladder

Due to Ch. Prostatitis ?

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

Major findings: Of operations none
Of autopsy none

Duration

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) (a) Means of injury _____

23. Signature A. H. Thornburgh (M. D. or other) MD
Address West Plains, Mo Date signed _____

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

MOTHER FATHER

SUPPLEMENTAL

