

5-17-39
X32873
FILED OCT 13 1942

Registration District No. **653**

Primary Registration District No. **5871**

1. PLACE OF DEATH:

(a) County **Demarest**
(b) City or town **Braggadocio**
(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
years, months or days

3. (a) PRINT FULL NAME **Franklin Madison**

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

4. Sex **male** 5. Color or race **white** 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 **9-29-1941**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
10 29 hr. min.

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

10. Usual occupation **✓**

11. Industry or business

12. Name **A. T. Mason**

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

14. Maiden name **Harriet Pullman**

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

16. (a) Informant **A. T. Mason**

(b) Address **Braggadocio MO**

17. (a) **Burial** (b) Date thereof **9-27-42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Braggadocio**

18. (a) Signature of funeral director **[Signature]**

(b) Address **Braggadocio**

19. (a) **9-30-42** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Demarest**

(c) City or town **Braggadocio**
(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 **27** day **Sept**
year **1942** hour **11** minute **9** P.M.

21. I hereby certify that I attended the deceased from **9/25**, 19**42**, to **9/27**, 19**42**,
that I last saw him alive on **9/25**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Dysentery**

Duration

7 days

Due to

Due to **27C**

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 **[Signature]** (M.D. or other)

Address **Carthageville MO** Date signed **9/28**

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

10-42-19

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.....

Licensed Embalmer No.....

P. O. Address.....

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. 31014
Registrar's No. 63

Registration District No. 653

Primary Registration District No. 5871

1. PLACE OF DEATH: Gemiscott
 (a) County.....
 (b) City or town..... Bruggessocio
 (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.....
 In this community.....
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State..... (b) County.....
 (c) City or town.....
 (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 Franklin D. Madison
 3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Sept day 7
 year 1942 hour 11 minute 17 M.
 21. I hereby certify that I attended the deceased from 9 19.....
 that I saw her alive on 9 19.....
 and that death occurred on the date and hour stated above.
 Immediate cause of death.....

4. Sex m. 5. Color or race N 6. (a) Single, widowed, married, divorced single
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive 29 years
 7. Birth date of deceased.....
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day min.
29 11 17

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.....
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation.....
 18. (a) Signature of funeral director.....
 (b) Address.....
 19. (a) 9/30/42 (b) Mrs O.G. Shrey
 (Date received local registrar) (Registrar's signature)

Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)
 Major findings:
 Of operations.....
 Of autopsy.....

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)
 (b) Did injury occur in or about home, on farm, in industrial place, in public place?
 (Specify type of place)
 While at work? (c) Means of injury.....
 23. Signature..... (M. D. or other).....
 Address..... Date signed.....

SUPPLEMENTARY

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

MOTHER FATHER

DEC 1 1969