

25732

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

FILED AUG 9 1943

Registration District No. 274

Primary Registration District No. 3052

Registrar's No. 225

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

S. No. 2
M-9-4-41
5-17-39
PI X29-282
80
6
4

1. PLACE OF DEATH:

(a) County **Pettis**

(b) City or town **Sedalia**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Bothwell Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **5 weeks**
72 Years (Specify whether years, months or days)

In this community **72 Years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Pettis**

(c) City or town **Sedalia**
(If outside city or town limits, write "RURAL")

(d) Street No. **500 W Broadway**
(If rural, give location)

(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **Ida Mae Frank**

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

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

6. (b) Name of husband or wife **Elmer Clay Frank** 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **March 5 1871**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

72 **4** **7**hr.min.

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

10. Usual occupation **at home**

11. Industry or business.....

12. Name **Isaac Warren**

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

14. Maiden name **Mollie Gentry**

15. Birthplace **Pettis Co. Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Edna Kurtz**

(b) Address **Sedalia Mo.**

17. (a) **burial** (b) Date thereof **July 14 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Crown Hill**

18. (a) Signature of funeral director **McLaughlin Bros.**
(b) Address **Sedalia Mo.**

19. (a) **7-14-43** (b) **Anna Berger**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July 12**
year **1943** hour **11:00** minute **45** A. M.

21. I hereby certify that I attended the deceased from **Sept 22**, 1944, to **July 12**, 1943
that I last saw him alive on **July 12**, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebrus Sigmoid & obstruction**

Due to.....
Due to..... **H62**

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?.....
(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. Boyer** (Physician)
Address **Sedalia Mo** Date signed **7/13/43**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1022

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8;

District File Number.....

Date Filed 8-6-43

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 Robert H Reed

Licensed Embalmer No. 3745

P. O. Address Seaside Mo

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.