S. No. 2
M—5-42
v. 5-17-39
1 X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 31513

FILED OCT 6 1943

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 115

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

27
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1. PLACE OF DEATH:

(a) County: Cooper

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

(c) Name of hospital or institution: ST. JOSEPH'S HOSPITAL 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 1 week (Specify whether years, months or days)

In this community: 1 week

2. USUAL RESIDENCE OF DECEASED:

(a) State: MISSOURI (b) County: WEBSTER

(c) City or town: FORDLAND (RURAL) 112 0
(If outside city or town limits, write "RURAL")

(d) Street No.: R. F. D. 2 0
(If rural, give location)

(e) Citizen of foreign country?: No (Yes or No)

If yes, name country: /

3. (a) PRINT FULL NAME: EMMA LEONA FRANZ

3. (b) If veteran, name war: NONE

3. (c) Social Security No.: NONE

4. Sex: FEMALE 1

5. Color or race: WHITE

6. (a) Single, widowed, married, divorced: MARRIED 1

6. (b) Name of husband or wife: ANTONE FRANZ

6. (c) Age of husband or wife if alive: 65 years

7. Birth date of deceased: OCTOBER (Month) 12 (Day) 1882 (Year)

8. AGE: Years 60 Months 11 Days 1 If less than one day ____ hr. ____ min.

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

10. Usual occupation: HOUSEWIFE

11. Industry or business: HOME

FATHER
12. Name: EMANUEL RUSKE
13. Birthplace: (City, town, or county) FRANCE 5 (State or foreign country)

MOTHER
14. Maiden name: UNKNOWN
15. Birthplace: (City, town, or county) 9 (State or foreign country)

16. (a) Informant: ANTONE FRANZ
(b) Address: FORDLAND MO

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 9/14/43 (Month) (Day) (Year)
(c) Place: burial or cremation: FORDLAND - MO.

18. (a) Signature of funeral director: STEGNER - KOENIG
(b) Address: BOONVILLE - MO

19. (a) 9-14-43 (Date received local registrar) (b) Dr. Chas. Swap. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: SEPTEMBER 13th year: 1943 hour: 5 minute: P.M.

21. I hereby certify that I attended the deceased from 9-5-43, 19__, to 9-13, 1943 that I last saw her alive on 9-13, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral accident.	1 week
Left hemiplegia	1 week
Due to: Hypertension	Years
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? (Specify type of place)

While at work? (e) Means of injury: 0

23. Signature: Geo. W. Blankenship (M. D. or other) M.D.

Address: Boonville Mo. Date signed: 9-14-43

1088 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 8,
District
Date File 10-1-43

OCT 13 1943

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 James W. Stegner

Licensed Embalmer No. 3780

P. O. Address Boonville, 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.