No. 2
11-10-39
5-17-39
I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 1 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

37598

State File No.

Registration District No. 1 Primary Registration District No. 4000 Registrar's No. 266

1. PLACE OF DEATH:
(a) County: Adair
(b) City or town: Connelsville (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) 1
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Adair
(c) City or town: Novinger Mo. (If outside city or town limits write "RURAL")
(d) Street No. ✓ (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

8. (a) PRINT FULL NAME: Mrs. Eva Frankford
8. (b) If veteran, name war: ✓
3. (c) Social Security No.: ✓
4. Sex: female
5. Color or race: white
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: Robert Frankford
6. (c) Age of husband ~~or wife~~ if alive: 81 years
7. Birth date of deceased: Aug. 24, 1868 (Month) (Day) (Year)

8. AGE: Years 75 Months 1 Days 19 If less than one day hr. min.

9. Birthplace: Mt. Sterling Ill. (City, town, or county) (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: ✓
FATHER 12. Name: Henry Hickman
13. Birthplace: Mt. Sterling Ill. (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: D K
15. Birthplace: (City, town, or county) (State or foreign country) O
16. (a) Informant: Robert Frankford
(b) Address: Novinger, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-15-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Novinger Cemetery
18. (a) Signature of funeral director: Davis Funeral Home
(b) Address: Kirksville, Mo.
19. (a) 10/22/43 (Date received local registrar) (b) Mrs. J. L. Wagner (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 13 year 1943 hour 10 minute P. M.
21. I hereby certify that I attended the deceased from March, 1943, to Oct 13, 1943, that I last saw h. alive on Oct 13, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death: Angina Pectoris — Duration 1 hr
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? (Specify type of place)
While at work? (e) Means of injury: ✓
23. Signature: H. H. Garrison M.D. (M. D. or other)
Address: Novinger Mo Date signed 10-17-43

1049

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 11-43-1853
Date Filed NOV 16 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 A. J. Power

Licensed Embalmer No. 1407

P. O. Address Kirkwood

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.