

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state

Registration District No. 2 Primary Registration District No. 4009

1. PLACE OF DEATH:  
 (a) County Andrew  
 (b) City or town SAVANNAH  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community 60 yrs. years, months or days

3. (a) PRINT FULL NAME PAUL Lenard Francil  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race W  
 6. (b) Name of husband or wife minnie 6. (a) Single, widowed, married, divorced m  
 6. (c) Age of husband or wife if alive 70 years  
 7. Birth date of deceased sept 1 1871 (Month) (Day) (Year)

8. AGE: Years 72 Months 4 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Ord (City, town, or county) neb. (State or foreign country)

10. Usual occupation Blacksmith

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Wm Knowl 9  
 13. Birthplace Wm Knowl 9 (City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Wm Knowl 9  
 15. Birthplace Wm Knowl 9 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Minnie Francil  
 (b) Address Savannah mo

17. (a) B. (Burial, cremation, or removal) (b) Date thereof 2-2-1944 (Month) (Day) (Year)  
 (c) Place: burial or cremation Savannah mo

18. (a) Signature of funeral director E. C. Breit  
 (b) Address Savannah mo

19. (a) 2-1-44 (Date received local registrar) (b) F. H. Fitchman (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State MISSOURI (b) County Andrew  
 (c) City or town SAVANNAH (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 29 year 1944 hour 10 minute A.M.

21. I hereby certify that I attended the deceased from Jan 23 1944 to Jan 29 1944 that I last saw him alive on Jan 23 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Embolism Duration \_\_\_\_\_

Due to Asthenic sclerosis

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 940

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 Kaeten Myers (M.D. or other) Address Savannah Date signed Jan 30 1944

**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..... *E. C. Breit*.....

Licensed Embalmer No. *2650*

P. O. Address *Savannah*

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

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