

**FILED JUN 24 1944**

Registration District No. **1944**

Primary Registration District No. **4428**

Registrar's No. **62**

**1. PLACE OF DEATH:**  
 (a) County Pulaski  
 (b) City or town Richland  
(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)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Mo (b) County Pulaski  
 (c) City or town Richland 95  
(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** Rebecca Frack  
**3. (b) If veteran,** name war \_\_\_\_\_  
**3. (c) Social Security** No. \_\_\_\_\_

**4. Sex** F **5. Color or race** W  
**6. (a) Single, widowed, married,** divorced  
Widow  
**6. (b) Name of husband or wife** \_\_\_\_\_  
**6. (c) Age of husband or wife if** \_\_\_\_\_  
 alive \_\_\_\_\_ years

**7. Birth date of deceased** Apr 12 1842  
(Month) (Day) (Year)  
**8. AGE:** Years 102 Months 1 Days 15  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

**9. Birthplace** Galesburg Penn  
(City, town, or county) (State or foreign country)

**10. Usual occupation** Housewife

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

**12. Name** unknown

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

**14. Maiden name** unknown

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

**16. (a) Informant** W B Frack

**(b) Address** Richland Mo

**17. (a) Burial, cremation, or removal** Burial **(b) Date thereof** 5/29/44  
(Month) (Day) (Year)

**(c) Place: burial or cremation** Chas Owen

**18. (a) Signature of funeral director** W B Frack

**(b) Address** Richland Mo

**19. (a) Date received local registrar** 6-7-44 **(b) Registrar's signature** Chas McOod  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month May day 27  
 year 1944 hour 1 minute 15 a.m.

**21. I hereby certify that I attended the deceased from** May 10, 1944, to May 27, 1944  
 that I last saw her alive on May 27, 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death Shock Duration 1 day  
 Due to Fall + brock left hip 1/10 days

Other conditions 1869  
(Include pregnancy within 3 months of death)

Major findings: 18  
 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 5/27

**23. Signature** Went A. Oliver (M. D. or other) \_\_\_\_\_

Address Richland, Mo. Date signed 6/29/44

MOTHER FATHER

**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. *3198*

P. O. Address..... *Puchland*

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

**If this body is not embalmed, fact should be so stated above.**

Registration District No. 290

Primary Registration District No. 4428

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Cyragku  
(b) City or town Richland  
(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 Rebecca Frank

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Apr. 12 1942  
(Month) (Day) (Year)

8. AGE: Years 102 Months 1 Days \_\_\_\_\_ (Unless than one day) \_\_\_\_\_ min.

9. Birthplace Penn.  
(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) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 21 Year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death Shock

Due to Fall & broke left hip Duration 1 day

Due to \_\_\_\_\_ Duration 10 days

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations 186a PHYSICIAN \_\_\_\_\_

Of autopsy 18 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) accident

(b) Date of occurrence May 21 1944

(c) Where did injury occur? In bedroom in home  
(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 Being out of bed to urinate

23. Signature Orville A. Oliver, M.D. Physician

Address Richland Mo Date signed 6.24.44

SUPPLEMENTARY

WHITE LABEL—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

B  
3  
6930

22290