

FILED OCT 9 1944
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Registration District No.

Primary Registration District No. 1000

Registrar's No. 975

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Methodist
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 1/2 days
Specify whether
In this community 1 year
years, months or days

3. (a) PRINT FULL NAME Joseph L Frank

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

4. Sex M O
5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased March 15 1874
(Month) (Day) (Year)

8. AGE: Years 86 Months 6 Days 18
If less than one day hr. min.

9. Birthplace Unknown Ill. (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

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 J Latimer
(b) Address North Missouri

17. (a) Removal (b) Date thereof Oct 3 - 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Great City Cemetery

18. (a) Signature of funeral director Jasper Anderson

(b) Address North Mo

19. (a) 10/3/44 (b) Helen Pickle
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Worth
(c) City or town Worth
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October 3d
year 1944 hour 12 minute 20 P. M.

21. I hereby certify that I attended the deceased from March 1942 to Oct 3d 1944
that I last saw him alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage 1 day
Due to Chronic Myo-Carditis and Mitral insufficiency 18 Mos

Other conditions: Semility
(Include pregnancy within 3 months of death)

Major findings: Of operations 93d

Of autopsy NO

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 H F Mundy (M. D. or other) 10/9/44
Address 464 So 3d st Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.....

Hayse Andrews....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Hayse Andrews*.....

Licensed Embalmer No. *2892*.....

P. O. Address..... *North 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.