

No. 2  
M-5-43  
5-17-39  
X36671

State File No. \_\_\_\_\_

FILED OCT 13 1944

Registration District No. 176

Primary Registration District No. 3026

Registrar's No. 244

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:  
Independence Sanitarium  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 weeks  
(Specify whether years, months or days)

In this community 27 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Independence 4  
(If outside city or town limits, write "RURAL")

(d) Street No. 717 N. Spring 12  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country 11

3. (a) PRINT FULL NAME RALPH R. FRANKLIN

3. (b) If veteran, name war None

3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mary Franklin

6. (c) Age of husband or wife if alive 30 years 1903

7. Birth date of deceased: April 30 1903  
(Month) (Day) (Year)

8. AGE: Years 41 Months 4 Days 14  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: Kansas City Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Meter reader

11. Industry or business City of Independence

MOTHER FATHER

12. Name Nephi C. Franklin

13. Birthplace Ogden Utah  
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Newton

15. Birthplace London England  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mary Franklin

(b) Address 717 N. Spring, Independence, Mo.

17. (a) Burial (b) Date thereof 9/16/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn

18. (a) Signature of funeral director George C. Carson Funeral

(b) Address Independence, Mo.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 14  
year 44 hour 11:30 minute A M.

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

Immediate cause of death Pulmonary embolism

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

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

Other conditions 111a  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy Metformin

Duration \_\_\_\_\_

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? \_\_\_\_\_

23. Signature COBETT 3/9/44  
(Specify type of place) (e) Means of injury

While at work \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

1163

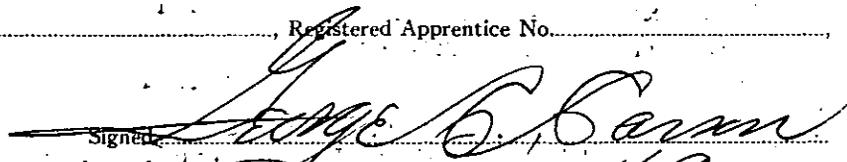
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**STATEMENT BY LICENSED EMBALMER**

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. 2249  
P. O. Address Independence, 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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. OctRegistration District No. 146 Primary Registration District No. 3026 Registrar's No. 254

## 1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Independence  
(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 NAMERalph R. Franklin3. (b) If veteran,  
name war.....3. (c) Social Security  
No. ....4. Sex M 5. Color or  
race W 6. (a) Single, widowed, married,  
divorced M6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if  
alive..... years7. Birth date of deceased April 30 1900  
(Month) (Day) (Year)8. AGE: Years 41 Months 0 Days 0 If less than one day  
in..... min.9. Birthplace.....  
(City, town, or county) (State or foreign country) MO.

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) 9-16-1944 (b) J. M. Rose  
(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 Sept  
year 1944 hour..... minute..... M.21. I hereby certify that I attended the deceased from  
19..... to..... 19.....;that I last saw him..... alive on..... 19.....;  
and that death occurred on the date and hour stated above,  
immediate cause of death.....

Duration

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?  
.....While at work?..... (Specify type of place)  
(c) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

31073