

Registration District No. FILED NOV 20 1944

Primary Registration District No. 1002

Registrar's No. 4544

1. PLACE OF DEATH:

(a) County Jackson

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

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

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 5 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson

(c) City or town Franklin City MO
(If outside city or town limits, write "RURAL")

(d) Street No. 709 Washington
(If rural, give location)

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

3. (a) PRINT FULL NAME Frank Raia

3. (b) If veteran, name war _____

3. (c) Social Security No. none

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased 18 5 2
(Month) (Day) (Year)

8. AGE: Years 92 Months - Days - If less than one day _____ hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

12. Name Do not know

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

14. Maiden name Do not know

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

16. (a) Informant Frank LaRocco

(b) Address 620 Brooklyn

17. (a) Burial (b) Date thereof Nov 12-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation mt St. Marys

18. (a) Signature of funeral director Benjamin Bros.

(b) Address Franklin City MO

19. (a) 11-11-44 (b) T. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 10
year 1944 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on _____, 19____, as Deputy Coroner
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Coronary Arteriosclerosis

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy Inspection

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)

23. Signature A. E. Upsher (M. D. or other) _____
123 McCoy Date signed 11/11/44

Address _____

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

Signed Francis Walton

Licensed Embalmer No. 2744

P. O. Address 12 CMO

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.