

FILED JAN 10 1945

State File No.

Registration District No. 260

Primary Registration District No. 6225

Registrar's No. 199

1. PLACE OF DEATH:

(a) County Winnon
(b) City or town St. Joseph
(c) Name of hospital or institution: State Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: 108-11 25 days
In this community at a home years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Wick
(c) City or town Marshfield
(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 no

3. (a) PRINT FULL NAME

WM. FRANK GEER

3. (b) If veteran, name war L

3. (c) Social Security No. ✓

4. Sex Male 5. Color or race white
(a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if 1943 years

7. Birth date of deceased June 19, 1913
(Month) (Day) (Year)

8. AGE: Years 31 Months 5 Days 7
If less than one day hr. 0 min. 0

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

10. Usual occupation none employed

11. Industry or business Sharn Beer

12. Name Sharn Beer

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

14. Maiden name Harriet Turner

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

16. (a) Informant Mrs. Ophelee

(b) Address Marshfield Mo

17. (a) Burial (b) Date thereof 12-9-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marshfield Mo

18. (a) Signature of funeral director Ray Burch

(b) Address Marshfield Mo

19. (a) 12-12-44 (b) Ray B. Burch
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 6 year 1944 hour 11 minutes 19 A.M.

21. I hereby certify that I attended the deceased from 1943 to Dec 6, 1944
that I last saw him alive on Dec 6, 1944 and that death occurred on the 6 day and hour stated above.

Immediate cause of death: Pneumonia Duration 1 day
Lobar acute

Due to Cardiac Insuf

Due to 100

Other conditions: 100
(Include pregnancy within 3 months of death)

Major findings: none
Of operations

Of autopsy: no

22. If death was due to external causes, fill in the following:

(c) 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? _____

(a) While at work? no (Specify type of place) _____

(e) Means of injury no

23. Signature R. G. Hall (M. D. or other) MD
Address 1276 1/2 Date signed 12/14/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1331

RECEIVED

Dir. of Health No. 7,

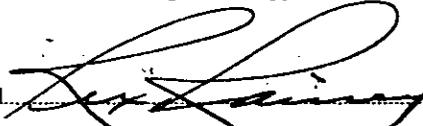
File No. 12-44-1438

Date Recd. 1-8-45

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. 3312

P. O. Address. Mansfield, 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.