

FILED FEB 6 1945 122

Registration District No. Primary Registration District No. 4201

Registrar's No. 1

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town Republic
(c) Name of hospital or institution: None
Republic, Missouri
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
In this community 1
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Caryal Lee Francis
3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife Single 6. (c) Age of husband or wife if alive, years 25, 1919
7. Birth date of deceased: February 25, 1919
(Month) (Day) (Year)

8. AGE: Years 25 Months 10 Days 20 If less than one day hr. min.

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

10. Usual occupation -

11. Industry or business -

MOTHER FATHER { 12. Name Lee Francis
13. Birthplace Collins, Missouri
14. Maiden name Cuba Wilson
15. Birthplace Collins, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Lee Francis
(b) Address Republic, Missouri

17. (a) Burial (b) Date thereof Jan 17, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East Lawn Cemetery

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home
(b) Address Springfield, Missouri

19. (a) Jan. 17, 1945 (b) Flourence Brittain
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene 39
(c) City or town Republic
(If outside city or town limits, write "RURAL.")
(d) Street No. 1
(If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 15
year 1945 hour 3:15 minute P. M.

21. I hereby certify that I attended the deceased from Jan 15, 1945 to Jan 15, 1945
that I last saw him alive on Jan 15, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis
Duration 18 mo

Due to -

Due to -

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

Major findings: Adventitious Tuberculosis
Of operations of Lung
Of autopsy none

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) (e) Means of injury 5

23. Signature E.L. Beal M.D. (M. D. or other)

Address Republic Mo Date signed 1/16/45

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

RECEIVED

REC'D 10 1945

Office,
County _____
Date Filed 7/3/45

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 Charles A. Roof

Licensed Embalmer No. 3044

P. O. Address Springfield, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb
Registrar's No. 1

Registration District No. 122 Primary Registration District No. 4201

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Republic
(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 Caryal L. Francis

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

4. Sex m 5. Color or race wn 6. (a) Single, widowed, married, divorced ✓

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

7. Birth date of deceased Feb. 25
(Month) (Day) (Year)

8. AGE: Years 25 Months 10 Days _____ If less than one day, _____ min.

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

10. Usual occupation _____

11. Industry or business Laborer

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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Gloria Britain
(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 _____ Day _____
year 1945 hour _____ minute _____ 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 _____

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) (e) Means of injury _____

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

Address _____ Date signed _____

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

SUPPLEMENTARY

S-2203