

**1. PLACE OF DEATH:**

(a) County Howard  
(b) City or town Rural Franklin Twp.  
(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 Life  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MISSOURI (b) County HOWARD CO.  
(c) City or town Rural Franklin Twp.  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME MARVIN C. AMICK

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE

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

7. Birth date of deceased MAY 9 1880  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
64 11 10 hr. min.

9. Birthplace HOWARD CO. MO (City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name JOHN F. AMICK  
13. Birthplace NORTH CAROLINA (City, town, or county) (State or foreign country)  
14. Maiden name SUSSIAN E. JONES  
15. Birthplace VIRGINIA (City, town, or county) (State or foreign country)

16. (a) Informant Mollie Amick  
(b) Address Franklin Mo

17. (a) BURIAL (b) Date thereof 4-21-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation B.O.N.S.B.O.V.O

18. (a) Signature of funeral director A.S. Duncan

(b) Address New Franklin Mo

19. (a) 4-23-45 (b) Conrad McMillan  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Apr. day 19  
year 1945 hour 3 minute 30 P.M.

21. I hereby certify that I attended the deceased from Feb 5 1945 to April 19 1945  
that I last saw her alive on April 15 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 13/1  
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 W. B. Blain (M. D. or other) 4-5  
Address 705 1/2 St Date signed \_\_\_\_\_

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

5-000

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 5/14/68

JUL 27 1968

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 H. L. Hall

Licensed Embalmer No. 35-15

P. O. Address New Franklin, 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.