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y. 5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23443**

FILED **17 1945**

Registration District No. **38**

Primary Registration District No. **3006**

Registrar's No. **185**

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

1. PLACE OF DEATH:
(a) County **Boone**
(b) City or town **Columbia**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **Ellis Frickel State Cancer Hosp.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 day**
In this community **1 day**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Platte** **83**
(c) City or town **Tracy** **0**
(If outside city or town limits, write "RURAL") **()**
(d) Street No. **()**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No) **1**
If yes, name country

3. (a) PRINT FULL NAME **Sales, Frank**
(b) If veteran, name war
(c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **June** day **21**
year **1945** hour **6** minute **15** p.M.
21. I hereby certify that I attended the deceased from **6-20** 1945, to **6-21** 1945;
that I last saw him alive on **19**;
and that death occurred on the date and hour stated above.

4. Sex **M O** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **Single**
6. (c) Age of husband or wife if **30** years
7. Birth date of deceased **Jan 30 1874**
(Month) (Day) (Year)

Immediate cause of death **Acute cardiac failure of heart** Duration **48 hrs**
Due to **old age**
Due to

8. AGE: Years **71** Months **4** Days **22** If less than one day hr. min.

9. Birthplace **Kansas** (City, town, or county) (State or foreign country) **1**

10. Usual occupation **Farm laborer**

11. Industry or business

12. Name **James Sales**

13. Birthplace **unknown** (City, town, or county) (State or foreign country) **9**

14. Maiden name **Adeline Craven**

15. Birthplace **unknown** (City, town, or county) (State or foreign country) **9**

16. (a) Informant **Warren Sales**

(b) Address **Tracy Missouri**

17. (a) **Rural** (Burial, cremation, or removal) (b) Date thereof **6-23-45**
(Month) (Day) (Year)

(c) Place: burial or cremation **Platte City, Mo**

18. (a) Signature of funeral director **Edna H. Barber**

(b) Address **Platte City, Mo.**

19. (a) **6-22-1945** (Date received local registrar) (b) **Edna H. Barber** (Registrar's signature)

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy **162 15**

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) Means of injury
23. Signature **R. H. Smith** (M. D. or other) **0**
Address **Cancer Hospital** Date signed **6/21/45**

1200 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 9

District File Number

Date Filed 7-16-45

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 Frances M. Liffie
Licensed Embalmer No. 4395
P. O. Address Blatte City, 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.