

## 1. PLACE OF DEATH:

(a) County Buchanan Platte, Fair  
 (b) City or town De Kalb Weston, Mo  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
About 4 miles south of Weston 3  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution (Specify whether  
 In this community entire life (Specify whether  
 years, months or days)

3. (a) PRINT FULL NAME DONALD STEVEN FRANKS3. (b) If veteran, name war none 3. (c) Social Security No. 499-09-8246

4. Sex Male (1) 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. November 1, 1912  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
32 10 8 hr. min.

9. Birthplace De Kalb Missouri 1  
(City, town, or county) (State or foreign country)10. Usual occupation Manager11. Industry or business Shoe Store12. Name Charles G. Franks13. Birthplace De Kalb Missouri  
(City, town, or county) (State or foreign country)14. Maiden name Edith Strong15. Birthplace Hintons Iowa 1  
(City, town, or county) (State or foreign country)16. (a) Informant Carl Franks(b) Address Kansas City, Missouri17. (a) Burial (b) Date thereof Sept 14, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation De Kalb Missouri18. (a) Signature of funeral director Savin Douglas(b) Address Atchison Kansas19. (a) 9-13-45 (b) Mrs. Ubbie Rollins  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan 11  
 (c) City or town De Kalb 0  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 0  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 9  
year 1945 hour 12 minute 30 a. M.21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on dead, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.Immediate cause of death Fracture of the skull  
car accident. DurationDue to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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

(a) Accident, suicide, ~~\_\_\_\_\_~~ (Specify) 83(b) Date of occurrence 9-8-45

(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) (c) Means of injury 323. Signature Tom H. Hulet (Dr. or other)Address Platte City Mo Date signed 9-9-45

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

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 ML

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

Signed

J. J. [Signature]  
Licensed Embalmer No. 4320  
P. O. Address St. Louis, Kans.

**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. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

(a) County Platte  
 (b) City or town Rural  
 (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 Donald S. Frakes3. (b) If veteran, name war none 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 November 1 1912  
(Month) (Day) (Year)8. AGE: <Years Months Days If less than one day  
32 10 8 hr. \_\_\_\_\_ min.9. Birthplace Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(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 \_\_\_\_\_ Year \_\_\_\_\_ Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_ that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_ and that death occurred on the date and hour stated above. Immediate cause of death: \_\_\_\_\_

State Highway Patrol

Due to \_\_\_\_\_

Non-Collision--Ran off Roadway

Due to \_\_\_\_\_

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

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## 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

MOTHER FATHER

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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