

No. 2  
 8-43  
 17-39  
 X37823

State File No. ....

**FILED** OCT 18 1945

Registration District No. ....

Primary Registration District No. 4413

Registrar's No. ....

**1. PLACE OF DEATH:**  
 (a) County Pike  
 (b) City or town Frankford  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution 1  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)  
 In this community 1 1/2 months

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Marion  
 (c) City or town Hannibal 3  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1712 Chestnut 4  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Julia Lee Sinclair  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month Sept day 15  
 year 1945 hour 3 minute 10 P.M.  
 21. I hereby certify that I attended the deceased from Aug 3  
1945 to Sept 15, 1945  
 that I last saw her alive on Sept 15, 1945  
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white  
 6. (a) Single, widowed, married, divorced widowed  
 6. (b) Name of husband or wife Fressan H. Sinclair  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased August 16 1894  
(Month) (Day) (Year)

Immediate cause of death Heart Failure  
 Duration \_\_\_\_\_

8. AGE: Years 51 Months 0 Days 29  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
**PHYSICIAN** \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

10. Usual occupation housewife  
 11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name Charles Feith  
 13. Birthplace Pike county Missouri  
(City, town, or county) (State or foreign country)  
 14. Maiden name WILLIE DE ARNT  
 15. Birthplace Pike county Missouri  
(City, town, or county) (State or foreign country)

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

16. (a) Informant James F. Sinclair  
 (b) Address 1712 Chestnut, Hannibal, Mo.  
 17. (a) Burial (b) Date thereof Sept 18, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Riverside Cemetery

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? \_\_\_\_\_

18. (a) Signature of funeral director Ray P. Schwartz  
 (b) Address 1000 Broadway, Hannibal, Mo.  
 19. (a) Sept 20/45 (b) Thermynt Stephens  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury.  
 23. Signature E. P. Harrison M.D. or other D.O.  
 Address Frankford 2 Date signed 9/16/45

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

AUG 4 1948

OCT 19 1945

RECEIVED  
District Health Officer No. 10  
District File Number 10-45-1617  
Date Filed OCT 17 1945

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 Jack N. Loken  
Licensed Embalmer No. 4110  
P. O. Address Harrisburg, Pa.

**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. 1102  
Registrar's No. \_\_\_\_\_

Registration District No. 278 Primary Registration District No. 4413

1. PLACE OF DEATH:  
(a) County Pike  
(b) City or town Frankford  
(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 Julia L. Sinclair  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race w  
6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased aug 16 1888  
(Month) (Day) (Year)

8. AGE: Years 51 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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

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

MOTHER FATHER

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 \_\_\_\_\_ Day \_\_\_\_\_  
year 1944 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 \_\_\_\_\_

Duration

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

Due to an abdominal, left breast & neck.

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 E. P. Hansen (M.D. or other) 1/20

Address Frankford, Mo. Date signed 10/23/45

SUPPLEMENTARY

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

34382