

No. 2
2-43
-17-39
138697

FILED DEC 4 1945

State File No.

Registration District No. 77

Primary Registration District No. 3016

Registrar's No. 261

1. PLACE OF DEATH:

(a) County Cole

(b) City or town Jefferson City, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1201 W Main St 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 65 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cole

(c) City or town Jefferson City Mo
(If outside city or town limits, write "RURAL")

(d) Street No. 1201 West Main St
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Miss Leona Frank

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 Single

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

7. Birth date of deceased June 30 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

70	4	10	hr. min.
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9. Birthplace Jefferson City Mo
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Nicholas Frank

13. Birthplace France
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Rautzel

15. Birthplace Cole Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Les C. Frank

(b) Address 1201 W Main St.

17. (a) Burial (b) Date thereof 11 23 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Resurrection Cemetery

18. (a) Signature of funeral director Thos J Gordon

(b) Address 217 E Mc Carthy St Jefferson City Mo

19. (a) 11-27-45 (b) R.P. Harris md
(Date received by local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 10 year 1945 hour 10 minute P. M.

21. I hereby certify that I attended the deceased from Nov. 2, 1945 to Nov 10, 1945

that I last saw h. in alive on Nov. 10, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis Duration 12 hrs.

Due to arteriosclerosis 5 yr.

Due to Myocarditis - Chronic 2 yr.

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

Major findings: Of operations 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 D. V. Sullivan (M. D. or other) M.D.

Address Jefferson City Mo. Date signed 11/27/45

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

RECEIVED
District Health Officer No. 9,

District File Number.....

Date Filed 12-3-45

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 Lea P. Dulle

Licensed Embalmer No. 3890

P. O. Address Jefferson 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.

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1. PLACE OF DEATH:

(a) County Cole

(b) City or town Jefferson city
(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..... (Yes or No)
years, months or days)

3. (a) PRINT FULL NAME Leona Frank

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 S

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

7. Birth date of deceased June 30
(Month) (Day) (Year)

8. AGE: Years 70 Months Days If less than one day
hr. min.

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

10. Usual occupation agch--

11. Industry or business Housekeeper

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) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) 11-27-45 (b) R.P. Davis MD
(Date received local registrar) (Registrar's signature)

12-12-45

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 7 1940
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.....

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

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