

S. No. 2  
 OM-8-13  
 v. 5-17-39  
 X37823

DEPARTMENT OF HEALTH  
 BUREAU OF THE CENSUS  
**FILED MAR 12 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. \_\_\_\_\_  
 Registrar's No. 94

Registration District No. 47

Primary Registration District No. 3008

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

1. PLACE OF DEATH:  
 (a) County Callaway  
 (b) City or town Fulton  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
State Hosp. #1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution Since Oct 29-1944  
 In this community since Oct 29, 1944  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Franklin  
 (c) City or town New Haven  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? DK (Yes or No)  
 If yes, name country DK

3. (a) PRINT FULL NAME Frank E. Bropp  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month March day 4  
 year 1947 hour 1:20 minute A M.  
 21. I hereby certify that I attended the deceased from December  
1, 1946, to March 4, 1947  
 that I last saw him alive on March 3, 1947  
 and that death occurred on the date and hour stated above.

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

Immediate cause of death Biliary Cirrhosis  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: Biliary Cirrhosis  
 Of operations \_\_\_\_\_  
 Of autopsy Acute yellow atrophy of liver  
T.B. Pulmonary Chronic hepatitis

7. Birth date of deceased DK DK DK  
 (Month) (Day) (Year)  
 8. AGE: Years Months Days If less than one day  
60 3 ? \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
 10. Usual occupation Farm work

11. Industry or business \_\_\_\_\_  
 12. Name DK  
 13. Birthplace DK (City, town, or county) \_\_\_\_\_ (State or foreign country)  
 14. Maiden name DK  
 15. Birthplace DK (City, town, or county) \_\_\_\_\_ (State or foreign country)

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 \_\_\_\_\_

16. (a) Informant Walter Brown  
 (b) Address Fulton Mo  
 17. (a) Burial (b) Date thereof 3-7-47  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation State Hosp. Cemetery  
 18. (a) Signature of funeral director H.P. Hall  
 (b) Address State Hosp. #1 Fulton Mo  
 19. (a) 3-7-1947 (b) James M. ...  
 (Date received local registrar) (Registrar's signature)

Signature Wayne G. ... (M. D. or other)  
 Address State Hospital No. 1  
 Date signed March 4, 1947

RECEIVED  
District Health Officer No. 9,  
District File Number 310-42  
Date Filed

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**