

U. S. No. 2  
DM-9-4-41  
Rev. 5-17-39  
I X29484

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 4509

FILED FEB 20 1947  
Registration District No. 1

Primary Registration District No. 4185

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

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

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town St. Clair

(c) Name of hospital or institution: \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days 73-2-7 days-

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Franklin

(c) City or town: St. Clair Mo  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Frank Jones

3. (b) If veteran, name war no

3. (c) Social Security No. 496-28-795-8

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 7  
year 1947 hour 12 minute P. M.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife Beckie

6. (c) Age of husband or wife if alive 4 years

7. Birth date of deceased 10-16-1873  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 7-10-1946 to 7-7-47  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
<u>73</u>	<u>2</u>	<u>7</u>		hr. _____ min. _____

Immediate cause of death Cancer mediastinal glands

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

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

10. Usual occupation laborer

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

11. Industry or business lumber

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

12. Name Frank Jones

Major findings: Cancer mediastinal glands

13. Birthplace Washington Co. Mo  
(City, town, or county) (State or foreign country)

Of operations \_\_\_\_\_

14. Maiden name Wass

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

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

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

16. (a) Informant Wass Shadrick

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

17. (a) Burial (b) Date thereof 1-9-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(b) Date of occurrence \_\_\_\_\_

18. (a) Signature of funeral director W. Z. Oye

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

19. (a) 1-8-1947 (b) E. A. Northington  
(Date received local registrar) (Registrar's signature)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

23. Signature W. Z. Oye (M. D. or other) \_\_\_\_\_  
Address St. Clair Mo Date signed 1/8/47

RECEIVED  
District Health Officer No. ( )  
District File Number 2-14-42  
Date Filed

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 *Sherwood Mitchell*  
Licensed Embalmer No. *3873*  
P. O. Address *St. Clair, 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.