

FILED DEC 12 1947

Registration District No. **278**

Primary Registration District No. **4413**

Registrar's No. **11**

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)  
 In this community Life  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pike **82**  
 (c) City or town Frankford **7**  
 (If outside city or town limits, write "RURAL") **1**  
 (d) Street No. \_\_\_\_\_ (If rural, give location) **0**  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 26  
 year 1947 hour 1 minute 15 P.M.

21. I hereby certify that I attended the deceased from June  
 \_\_\_\_\_, 1945, to Nov. 26, 1947.  
 that I last saw him alive on Nov. 26, 1947  
 and that death occurred on the date and hour stated above.

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

Due to Creeping Paralysis  
 Due to \_\_\_\_\_

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

Major findings:  
 Of operations 62  
 Of autopsy 0  
 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?  
 \_\_\_\_\_ (Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury 2

23. Signature E. P. Hansen (M. D. or other) DO.  
 Address Frankford Mo Date signed 11/29/47

3. (a) PRINT FULL NAME WALTER LEE SEE

3. (b) If veteran, name war WORLD WARI 3. (c) Social Security No. 494-20-6015

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married

(b) Name of husband or wife Josephine See 6. (c) Age of husband or wife if alive 39 years  
 7. Birth date of deceased August 14 1894  
 (Month) (Day) (Year)

8. AGE: Years 53 Months 3 Days 12  
 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Hunnell No - 1  
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer retired

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

MOTHER FATHER { 12. Name James Morris See  
 13. Birthplace Hunnell No 1  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Anna Hamilton  
 15. Birthplace Hunnell No 1  
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Walter See  
 (b) Address Frankford, Mo

17. (a) Nov. 28 47 (b) Date thereof Nov 28 47  
 (Burial, cremation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Frankford, Mo -

18. (a) Signature of funeral director Fieldred Sox  
 (b) Address Frankford, Mo -

19. (a) 12/5/47 (b) Bernice Collier  
 (Date received local registrar) (Registrar's signature)

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

JAN 15 1948

RECEIVED  
District Health Officer No. 1  
District Number 12-47-16  
Date Filed DEC 10 1947

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 Joe Fields Mcgown

Licensed Embalmer No. 40930

P. O. Address. Frankfort, 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.