FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JUL 26 1948
Registration District No. 42

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22183

Primary Registration District No. 1000

Registrar's No. 759

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph 4
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1213 No. 10th - Littler Nursing Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community unknown
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Buchanan 11

(c) City or town St Joseph 1
(If outside city or town limits, write "RURAL")

(d) Street No. 1213 North 10th St. 7
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME FRANK - BLACK

3. (b) If veteran, name war unknown

3. (c) Social Security No. unknown

4. Sex Male

5. Color or race wht

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

6. (b) Name of husband or wife unk

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

7. Birth date of deceased unk (Month) - - (Day) - - (Year)

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

9. Birthplace unk (City, town, or county) 0 (State or foreign country)

10. Usual occupation Labor 1

11. Industry or business

FATHER
12. Name unk 0
13. Birthplace unk (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name unk
15. Birthplace unk (City, town, or county) 9 (State or foreign country)

16. (a) Informant Records of Welfare Board
(b) Address St. Joseph

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-14-48 (Month) (Day) (Year)
(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director Stanley Funeral Home
(b) Address St Joseph MO

19. (a) 7-17-48 (Date received local registrar) (b) E. C. Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10
year 1948 hour 4:30 minute a M.

21. I hereby certify that I attended the deceased from July 8, 1948 to July 10, 1948
that I last saw him alive on July 9, 1948
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Intertrochanteric fracture of left hip. Chronic Myocarditis	3 days Ukn.
Due to XXX	
Due to XXX	
Other conditions XXX (Include pregnancy within 3 months of death)	
Major findings: Of operations XXX	
Of autopsy XXX	

PHYSICIAN

Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident - fell
(b) Date of occurrence 7-7-48
(c) Where did injury occur Nursing Home, 1213 N. 10, St. Joseph Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Nursing Home (Specify type of place)
While at work? No (e) Means of injury Fell on floor

23. Signature Owen W. Craig (M. D. or other) 0
Address The Tootle Building St. Joseph, Missouri Date signed 7-12-48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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 John Roy Stamm

Licensed Embalmer No. 2435

P. O. Address St Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.