

FILED AUG 2 1948

Registration District No. 360

Primary Registration District No. 6225

State File No. \_\_\_\_\_

Registrar's No. 99

1. PLACE OF DEATH:

(a) County VERNON  
 (b) City or town Washington Twp  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
STATE HOSPITAL #3 2  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution See 032884  
(Specify whether)  
 In this community same  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 000  
 (c) City or town St. Louis Missouri 17  
(If outside city or town limit, write "RURAL")  
 (d) Street No. 4410 A North 20th ST 1  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME FRANKIE FLOREACE VOSSMEYER

8. (b) If veteran, name war no 3. (c) Social Security No. unknown

4. Sex F 1 5. Color or race W 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive none years

7. Birth date of deceased October 21 1890  
(Month) (Day) (Year)

8. AGE: Years 57 Months 8 Days 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace ST. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation none

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

12. Name HERMAN W. VOSSMEYER

13. Birthplace ST. Louis Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name FRANCES FINCH

15. Birthplace ST. Louis Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Records

(b) Address STATE HOSPITAL #3

17. (a) Removal (b) Date thereof July 25 48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis, Mo -

18. (a) Signature of funeral director Wm. C. Buehler

(b) Address Newbern, Mo -

19. (a) 7-26-48 (b) Malheur Vancuy  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 25  
 year 1948 hour 12 minute 25 A. M.

21. I hereby certify that I attended the deceased from Jan 12 1948 to July 25 1948  
 that I last saw her alive on July 24 1948  
 and that death occurred on the date and hour stated above.

Immediate cause of death CARCINOMA CERVIX UTERI WITH ABDOMINAL CARCINOMATOSIS  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions MENTAL DEFICIENCY  
(Include pregnancy within 3 months of death)

Major findings: Of operations NO  
 Of autopsy NO

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 JAMES J. PARSONS (M. D. or other) MD  
 Address State Hospital #3 Date signed 7-25-48

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 7

District File Number 6-48-864

Date Filed 7-31-48

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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

*Wm. E. Eichen*

Licensed Embalmer No.

*2656*

P. O. Address

*Devala, 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, above space should be left blank.