DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 24 1949

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 42484

Registration District No. 141 Primary Registration District No. 5551 Registrar's No. 74

1. PLACE OF DEATH:
(a) County Howell
(b) City or town Rural - West Plains
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 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 2 years.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo - (b) County Howell
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME William Franklin Cain -
3. (b) If veteran, name war None
3. (c) Social Security No. 431-20-3356.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Marie Cain
6. (c) Age of husband or wife if alive 52 years
7. Birth date of deceased June 24, 1890 (Month) (Day) (Year)

8. AGE: Years 58 Months 3 Days 10 If less than one day hr. min.

9. Birthplace Camp Ark. (City, town, or county) (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER
12. Name Jacob Cain
13. Birthplace Missouri (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Sarah Sutherland
15. Birthplace Tennessee (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Marie Cain
(b) Address West Plains, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-6-48 (Month) (Day) (Year)
(c) Place: burial or cremation Camp, Ark. Cemetery
18. (a) Signature of funeral director Higginbotham Funeral Serv.
(b) Address Salem Ark.
19. (a) Jan 10-49 (Date received local registrar) (b) Beatrice Cook (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 4 year 1948 hour 7:00 minute A. M.
21. I hereby certify that I attended the deceased from Sept 10, 1948 to Oct. 4, 1948 that I last saw him alive on Oct. 4, 1948 and that death occurred on the date and hour stated above.
Immediate cause of death Chronic Endocarditis (valvular disease) Duration
Due to Cardio-Renal vascular Disease
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

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
23. Signature Dr. Richard A. Smith (M.D. or other) D.O.
Address West Plains, Mo. Date signed 1-8-49

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 1-17-49
Health Officer No. 6
File Number 14545
Date Filed 1-18-49

SEP 18 1957

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 J. H. Best

Licensed Embalmer No. 659

P. O. Address Pocahontas, Ark.

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

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