

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

3774

State File No.

No. 300
10-48
FILED FEB 4 1949

BIRTH NO. _____		REG. DIST. NO. <u>381</u>		PRIMARY REG. DIST. NO. <u>4573</u>		Registrar's No. <u>6</u>	
1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Sullivan</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Milan</u>		c. LENGTH OF STAY (in this place) <u>3 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Milan</u>		d. STREET ADDRESS (If rural, give location) <u>9</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Alva</u> b. (Middle) <u>Erwin</u> c. (Last) <u>Franklin</u>			4. DATE OF DEATH (Month) <u>1</u> (Day) <u>26</u> (Year) <u>1949</u>				
5. SEX <u>W</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>2-1-1899</u>	
9. AGE (In years last birthday) <u>49</u>		10. UNDER 1 YEAR (Months) <u>6</u> (Days) <u>25</u>		10. UNDER 2 HRS. (Hours) <u>1</u> (Min.) <u></u>		11. BIRTHPLACE (State or foreign country) <u>Milan</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Milan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>J.C. Franklin</u>		13b. MOTHER'S MAIDEN NAME <u>Molly Jones</u>		14. NAME OF HUSBAND OR WIFE <u>Ona Korresler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>486-12-7319</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Ona Franklin</u>		ADDRESS <u>Milan</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>Coronary Thrombosis</u>				MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>			
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary Heart disease</u>				2 mo.			
DUE TO (c) <u>Chronic Nephritis</u>				1 yr.			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Poorly functioning Liver</u>				3 mo.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Eq 9 2X</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) <u>Milan</u> (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 20, 1948</u> , to <u>Jan 26, 1949</u> that I last saw the deceased alive on <u>Jan 26, 1949</u> , and that death occurred at <u>1 1/2</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Ed Simpson M.D.</u>				23b. ADDRESS <u>Milan</u>		23c. DATE SIGNED <u>1-27-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>1/29/49</u>		24c. NAME OF CEMETERY OR-CREMATORY <u>Oakwood Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Milan Sullivan Mo</u>	
DATE REC'D BY LOCAL REG. <u>Feb. 1-1949</u>		REGISTRAR'S SIGNATURE <u>Mrs. H. B. Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Schoene Funeral Home</u>		ADDRESS <u>Milan</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

25
1

RECEIVED

District Health Officer No. 10

District File Number 249-224

Date Filed FEB 2 - 1949

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 _____

D. Morris Cleeton

Student Embalmer No. 238

working under my personal supervision.

Student D. Morris Cleeton
Student Embalmer

Signed Dwight Schauer

Licensed Embalmer No. 2667

P. O. Address Urbana - Ill.

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.