

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38140**

FILED DEC 12 1949

BIRTH NO. _____ REG. DIST. NO. **255** PRIMARY REG. DIST. NO. **5875** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Oregon		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE Missouri b. COUNTY Ozark	
b. CITY (If outside corporate limits, write RURAL and give township) Thomasville		c. CITY (If outside corporate limits, write RURAL and give township) Thomasville	
c. LENGTH OF STAY (in this place) 6 days		d. STREET ADDRESS R. F. D.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3			

3. NAME OF DECEASED (Type or Print) James	a. (First)	Martin	b. (Middle)	Frank	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 9-29-49
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH 12-22-1878	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Hatterson Mo	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Wm Frank	13b. MOTHER'S MAIDEN NAME Mary Davis	14. NAME OF HUSBAND OR WIFE Willet F. Frank
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)	16. SOCIAL SECURITY NO. 3	17. INFORMANT'S SIGNATURE OR NAME Willet F. Frank	ADDRESS Thomasville Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myocarditis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4222	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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) (COUNTY) (STATE)
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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?
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Ch. Williams M.D.	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 10-2-49	24c. NAME OF CEMETERY OR CREMATORY Thomasville	24d. LOCATION (City, town, or county) (State) Thomasville Mo
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DATE REC'D BY LOCAL REG. 12-16-49	REGISTRAR'S SIGNATURE ma W.C. Johnson	25. FUNERAL DIRECTOR'S SIGNATURE Robertson	ADDRESS Thomasville Mo
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4-5. (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

11/30/49

District Health Officer No. 5,

District File Number: 1249763

Date Filed 12/2/49

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

working under my personal supervision.

Student
Student Embalmer

Student Embalmer No.

Signed

R. J. Deane

Licensed Embalmer No. 4697

P. O. Address

West Haven

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

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