

FILED APR 19 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12519
Registrar's No. 15

BIRTH NO. _____ REG. DIST. NO. 112 PRIMARY REG. DIST. NO. 5428

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Franklin | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Franklin | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Boone Tws. | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Boone Tws. | |
| c. LENGTH OF STAY (in this place) 6 mos. | | d. STREET ADDRESS (If rural, give location) Sullivan Mo. RR2 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Sullivan Mo. RR2 | | | |

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|---|---------------------|-------------|-----------|---|
| 3. NAME OF DECEASED (Type or Print) Charlie | a. (First) Franklin | b. (Middle) | c. (Last) | 4. DATE OF DEATH (Month) (Day) (Year) March 28 1950 |
|---|---------------------|-------------|-----------|---|

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|-------------|------------------------|--|--------------------------------|------------------------------------|------------------------|----------------------|-----------------------|----------------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married | 8. DATE OF BIRTH Mar. 31, 1882 | 9. AGE (In years last birthday) 68 | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 1 YEAR Hours | IF UNDER 1 YEAR Min. |
|-------------|------------------------|--|--------------------------------|------------------------------------|------------------------|----------------------|-----------------------|----------------------|

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|---|-----------------------------------|---|----------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Unknown | 12. CITIZEN OF WHAT COUNTRY? USA |
|---|-----------------------------------|---|----------------------------------|

| | | |
|----------------------------|-----------------------------------|----------------------------------|
| 13a. FATHER'S NAME Unknown | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE none |
|----------------------------|-----------------------------------|----------------------------------|

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|--|------------------------------|--|-----------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | 16. SOCIAL SECURITY NO. none | 17. INFORMANT'S SIGNATURE OR NAME Wm. Weiskopf | ADDRESS Sullivan, 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, asthenia, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Bronchitis | | INTERVAL BETWEEN ONSET AND DEATH 5021 |
| | 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. | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION No operation | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) |
|--|--|---|

| | | |
|--|--|----------------------------|
| 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 3-20, 1950, to 3-28, 1950 that I last saw the deceased alive on 3-27, 1950 and that death occurred at 8 a. m., from the causes and on the date stated above.

| | | | |
|-----------------------------------|-------------------|----------------------------|--------------------------|
| 23a. SIGNATURE J.K. Matthews M.D. | (Degree or title) | 23b. ADDRESS Jefferson Mo. | 23c. DATE SIGNED 3-29-50 |
|-----------------------------------|-------------------|----------------------------|--------------------------|

| | | | |
|--|-------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 3/30/50 | 24c. NAME OF CEMETERY OR CREMATORY Laubinger Cemetery | 24d. LOCATION (City, town, or county) (State) Franklin Co. Missouri |
|--|-------------------|---|---|

| | | | |
|----------------------------------|-------------------------------------|--|---------|
| DATE REC'D BY LOCAL REG. 3-29-50 | REGISTRAR'S SIGNATURE J.K. Matthews | 25. FUNERAL DIRECTOR'S SIGNATURE P. P. Shaffer | ADDRESS |
|----------------------------------|-------------------------------------|--|---------|

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

3360

RECEIVED
3-14-52
District Health Officer No. 9,
District File Number

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.....

Student Embalmer No.

working under my personal supervision.

Signed J. A. Humphrey

Signed.....
Student Embalmer

Licensed Embalmer No. 4772

P. O. Address Sullivan, Missouri

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.