S. No. 300
Rev. 10-48

FILED NOV 17 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38380

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5466 Registrar's No. 996

0390

1. PLACE OF DEATH
a. COUNTY: Greene
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, S.Campbell Twp.
c. LENGTH OF STAY (In this place): 3yr. 1mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Medical Center for Federal Prisoners

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Wisconsin
b. COUNTY: Shawano
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Keshena 8480
d. STREET ADDRESS (If rural, give location): Unknown 8

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle): ---
c. (Last): Frank

4. DATE OF DEATH (Month) (Day) (Year): November 7, 1952

5. SEX: Male 4
6. COLOR OR RACE: Indian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Unknown 4
8. DATE OF BIRTH: January 6, 1867
9. AGE (In years last birthday): 85 | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Wisconsin /
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: (first name unknown) Frank
13b. MOTHER'S MAIDEN NAME: Louise Mosehot
14. NAME OF HUSBAND OR WIFE: Agnes (Starr) Frank

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: FILE, M.C.F.P., Springfield, Missouri

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.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary congestion and edema

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Circulatory failure
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of the stomach

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: 11-4-52
19b. MAJOR FINDINGS OF OPERATION: Carcinoma of the stomach 151X
20. AUTOPSY? YES [X] NO [ ]

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 [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?: ------

22. *I hereby certify that I, attended the deceased from* The Medical Staff Sept. 16, 19 49, *to* Nov. 7, 19 52, *that I last saw the deceased alive on* Nov. 7, 19 52, *and that death occurred at* 11:35 pm., *from the causes and on the date stated above.*

23a. SIGNATURE E.C. Rinck (Degree or title): E.C. RINCK, M.D., Clinical Director
23b. ADDRESS: Medical Center for Fed. Prisoners, Springfield, Mo.
23c. DATE SIGNED: 11-10-52

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 11/11/1952
24c. NAME OF CEMETERY OR CREMATORY: ---
24d. LOCATION (City, town, or county) (State): Gresham Wisconsin

DATE REC'D BY LOCAL REG.: 11-12-52
REGISTRAR'S SIGNATURE: Edith Williamson Deputy Reg.
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: AYRE-GOODWIN FUN'L SERVICE, Spgfld, MO.,

(Licensed Embalmer's Statement on Reverse Side)

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

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 Embalmer No. _____

Signed _____
Student Embalmer

Signed _____

Licensed Embalmer No. 4594

P. O. Address Springfield, 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.