

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **365**
Registrar's No. **94**

FILED JAN 21 1954

BIRTH NO. _____ REG. DIST. NO. **43** PRIMARY REG. DIST. NO. **3007**

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Butler	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Poplar Bluff, MO.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Poplar Bluff	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 314 North G St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 314 North G St.			

3. NAME OF DECEASED (Type or Print)	a. (First) Joseph	b. (Middle) Daniel	c. (Last) Francis	4. DATE OF DEATH (Month) (Day) (Year) Jan. 6, 1954
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5. SEX <input checked="" type="checkbox"/> Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 1, 1874	9. AGE (In years last birthday) 80	# UNDER 1 YEAR 0	# UNDER 1 YEAR 5	# UNDER 1 MIN. 1
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rail Road	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Madison County, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME David Francis	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Unknown
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Joe Francis	ADDRESS Essex, 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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Senility DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? 4222 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) (Min.)	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 **10:00 pm.**, from the causes and on the date stated above.

23a. SIGNATURE Robert Lee Boardman	(Design or title) Poplar Bluff, Mo.	23b. ADDRESS	23c. DATE SIGNED Jan 11-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1-6-54	24c. NAME OF CEMETERY OR CREMATORY Bernie	24d. LOCATION (City, town, or county) (State) Bernie, Mo.
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DATE RECEIVED BY LOCAL REG. 1/14/54	REGISTRAR'S SIGNATURE Frank Cotrell	25. FUNERAL DIRECTOR'S SIGNATURE Frank-Cotrell	ADDRESS Poplar Bluff, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
JAN 18 1954
BUTLER CO. HEALTH CENTER
FILE No. _____

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.

Student _____
Student Embalmer

Signed Willie R Knight

Licensed Embalmer No. 4514

P. O. Address 412 Wm Poplar Bluff, Mo.

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.