

33951-53

## STANDARD CERTIFICATE OF DEATH

State File No. 10

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BIRTH FILED MAR 15 1954 REG. DIST. NO. 381 PRIMARY REG. DIST. NO. 4515 Registrar's No. \_\_\_\_\_

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> c. CITY OR TOWN <u>Milan</u>	
b. CITY OR TOWN <u>Milan</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>9 mo.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Billy</u> b. (Middle) <u>Ray</u> c. (Last) <u>Franklin</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3-7-1954</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>5-31-1953</u>
9. AGE (In years) (Month) (Day) (Year) <u>9</u> <u>6</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) <u>Milan - Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13a. FATHER'S NAME <u>Russell Franklin</u>		13b. MOTHER'S MAIDEN NAME <u>Opal Daniel</u>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>Russell Franklin - Milan Mo</u>	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congenital Malformations</u> ANTECEDENT CAUSES As for conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Unknown cause</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Megalocephaly, congenital cataract</u> Conditions contributing to the death but not related to the disease or condition causing death. <u>Undescended left testicle</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>7593</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:15</u> p.m., from the causes and on the date stated above.	
23a. SIGNATURE <u>Joseph E. Proctor</u> (Degree or title)		23b. ADDRESS <u>2176 2nd St. Milan</u>	
23c. DATE SIGNED <u>3-9-54</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>3-9-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Myers Cem.</u>	
24d. LOCATION (City, town, or county) (State) <u>Queen City - Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Schoelle</u> ADDRESS <u>Milan Mo</u>	
DATE REC'D BY LOCAL REG. <u>March 9-1954</u>		REGISTRAR'S SIGNATURE <u>Mrs. H. B. Harris</u>	

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Dwight Schoene

Licensed Embalmer No. 2667

P. O. Address Wuhan - 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.