

NOVEMBER 27 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40928**
Registrar's No. **5485**

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH
a. COUNTY **Jackson**

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE **Missouri** b. COUNTY **Jackson**

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **Kansas City**

c. LENGTH OF STAY (in this place) **89 Yrs.**

c. CITY OR TOWN **Kansas City**

d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION **St. Joseph Hospital**

STREET ADDRESS (If rural, give location) **4100 Prospect**

3. NAME OF DECEASED
a. (First) **DORA** b. (Middle) **R.** c. (Last) **FRANKE**

4. DATE OF DEATH (Month) (Day) (Year) **Nov. 29, 1954**

5. SEX **Female**

6. COLOR OR RACE **White**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Widowed**

8. DATE OF BIRTH **May 15, 1865**

9. AGE (in years last birthday) **89**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **At Home**

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and State or Foreign Country) **Kansas City, Missouri**

12. CITIZEN OF WHAT COUNTRY? **U. S. A.**

13a. FATHER'S NAME **Peter Reinhardt**

13b. MOTHER'S MAIDEN NAME **Barbara Kraft**

14. NAME OF HUSBAND OR WIFE **August H. Franke**

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 ADDRESS **Mrs. Flossie R. Jenkinson, K. C. Mo.**

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, ashenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Bellary cirrhosis**
Cholangitis
DUE TO (b) **Common duct stone**
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH
few
mo.
few yrs
584X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES 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) (Minute)

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 **10-25, 1954** to **11-29, 1954**, that I last saw the deceased alive on **11-28, 1954**, and that death occurred at **3:40 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE **D. Peterson MD**

23b. ADDRESS **3939 Prospect**

23c. DATE SIGNED **11-29-54**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial**

24b. DATE **12-1-54**

24c. NAME OF CEMETERY OR CREMATORY **Elmwood**

24d. LOCATION (City, town, or county) (State) **Kansas City, Mo.**

DATE REC'D BY LOCAL REG. **11-29-54** REGISTRAR'S SIGNATURE **Neva Marshall**

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **Freeman Mortuary Kansas City, Mo.**

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
B. Atcheson

WA 6110
1:30 to 6 PM Monday

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.....
Signature of Student Embalmer

Signed *Walter H. Erwin*

Licensed Embalmer No. *435*

P. O. Address *Kansas 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. ...
If this body is not embalmed, fact should be so stated above.