

FILED OCT 3 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30704

STATE FILE NUMBER

69816-56 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4052

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b> <b>7005</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <b>Kansas City</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>Independence</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Menorah Medical Center</b> Length of stay in 1b <b>1hr. 40 min.</b>		d. STREET (If outside, give location) ADDRESS <b>10915 Truman Rd.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>Deborah Kay Franke</b> <i>First Middle Last</i>			4. DATE OF DEATH <b>September 15 1956</b> <i>Month Day Year</i>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-15-56</b>	9. AGE (In years last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	11. BIRTHPLACE (City and state or country) <b>Kansas City, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Robert J. Franke</b>			14. MOTHER'S MAIDEN NAME <b>Davi J. Morris</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Robert J. Franke</b> Address <b>10915 Truman Rd. Ind., Mo.</b>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Non-viable premature</b>		INTERVAL BETWEEN ONSET AND DEATH <b>776X</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>6 mo gestation - spontaneous labor</b>	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____
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21. I attended the deceased from **Sept. 15, 1956** to **Sept. 15, 1956** and last saw her/him alive on **Sept. 15, 1956**  
Death occurred at **7:40 A. m.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>F. E. Baum, M.D.</b> (Degree or title) <b>D</b>	22b. ADDRESS <b>701 E. 63rd</b>	22c. DATE SIGNED <b>9-16-56</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9-17-56</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet, Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Hickman Mills, Mo.</b>
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24. FUNERAL DIRECTOR <b>Melody-McGilley-Eylar</b> ADDRESS <b>1800 E. Linwood</b>	25. DATE RECD. BY LOCAL REG. <b>9-16-56</b>	26. REGISTRAR'S SIGNATURE <b>Nevar Minshall</b>
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(Licensed Embalmers' Statement on Reverse Side)

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

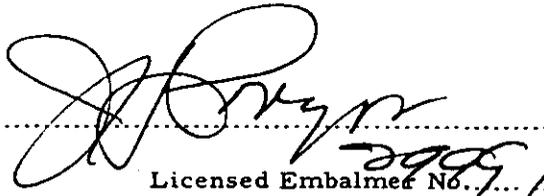
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION  
F. E. Baum

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
  
Licensed Embalmer No.....

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. ( 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.