

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5919

STATE FILE NUMBER

FILED FEB 18 1957

Registration District No. 316

Primary Registration District No. 3059

Registrar's No. 47

Health, Welfare, Public Service
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-56
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>ST. FRANCOIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. FRANCOIS</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BONNE TERRE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>BONNE TERRE</u>		8941 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BONNE TERRE HOSPITAL Ida.</u>			Length of stay in lb.		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JOEV</u> Middle <u>LEE</u> Last <u>FRANKLIN</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 11, 1957</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS.:	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>BONNE TERRE, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID LEE FRANKLIN</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Wilfong</u>			
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. <u>None</u>		17. INFORMANT Address <u>David Lee Franklin Flat River, Mo.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hypaline Membrane Syndrome</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (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) <u>Prematurity</u>							INTERVAL BETWEEN ONSET AND DEATH
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.) <u>2</u>				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)				
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from <u>1-11-57</u> to <u>1-12-57</u> and last saw <u>him</u> alive on <u>1-11-57</u> Death occurred at <u>10:00 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>F. Richard Cronin, M.D.</u>				22b. ADDRESS <u>Farmington Mo.</u>		22c. DATE SIGNED <u>2-8-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>JAN 13, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. FRANCOIS MEM. PARK</u>		23d. LOCATION (City, town, or county) (State) <u>BONNE TERRE, MO.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Raymond Caldwell and Sons Flat River, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Feb. 8, 1957</u>		26. REGISTRAR'S SIGNATURE <u>Esther Rudolph</u>		

(Licensed Embalmer's Statement on Reverse Side)

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 *R. Caldwell*

Licensed Embalmer No. *25*

P. O. Address *Flat B*

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.