

Dr. Murphy

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022168

FILED JUN 25 1959 Registration District No. 209 Primary Registration District No. 3043 STATE FILE NUMBER Registrar's No. 181

1. PLACE OF DEATH a. COUNTY <u>Marion</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Hannibal</u>		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>St. Elizabeth</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>1616 Hatch Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Barbara Ann Franz</u>			4. DATE OF DEATH Month Day Year <u>June 14, 1959</u>		
5. SEX <u>Female</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>July 14, 1891</u>		9. AGE (In years last birthday) <u>67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse Aide</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>H. Elizabeth Hospital</u>	11. BIRTHPLACE (City and state or country) <u>Edina, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Andrew Franz</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Hader</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 Address <u>Miss Odelia Franz, 1616 Hatch Ave., Hannibal, 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>Convulsions, cause undetermined</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Fractured skull</u>				<u>5 days</u>	
DUE TO (c) <u>Compound comminuted fracture ulna &amp; radius both arms</u>				<u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>9020 21</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>	
20a. ACCIDENT <input checked="" 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>patient fell from porch at home. banister broke.</u>			
20c. TIME OF INJURY Hour a.m. p.m. <u>6/9/59</u>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Hannibal, Marion Missouri</u>	
21. I attended the deceased from <u>6/9/59</u> to <u>6/14/59</u> and last saw her alive on <u>6/14/59</u> Death occurred at <u>11:35 A. M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>[Signature]</u>			22b. ADDRESS <u>100 N. 6th, Hannibal, Mo.</u>		22c. DATE SIGNED <u>6/17/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>June 17, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hannibal, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>H.M.O. Donnell, Hannibal, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>6-23-59</u>		26. REGISTRAR'S SIGNATURE <u>Dr. E.M. Lucke By W.C. Fisher</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *J. M. O'Donnell* .....

Licensed Embalmer No. 3889.....  
P. O. Address Hannibal, 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.