

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 15 1960

43

Primary Registration District No. 3007

Registrar's No. 17

'59 0 4 3 4 7 6
STATE FILE NUMBER

ENDED

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|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Butler | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Butler | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Poplar Bluff | | Length of stay in 1b Life | c. CITY OR TOWN Poplar Bluff Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lucy Lee Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 641 N. Main Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|----------------------------------|---|--|---|---|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last Catherine Martha Frank | | | 4. DATE OF DEATH Month Day Year December 19, 1959 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 1/17/1867 | 9. AGE (last birthday) 92 | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. 11 2 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (City and state or country) Butler County Mo. | | 12. CITIZEN OF WHAT COUNTRY U. S. A | |
| 13a. FATHER'S NAME Wm. Turner | | 13b. MOTHER'S MAIDEN NAME Martha Davis | | 14. NAME OF HUSBAND OR WIFE Deceased | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Dr. Walter Frank. Jacksonville, Ill | | |

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|---|---|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Cerebral Hemorrhage | | 24 hrs. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Arteriosclerosis, generalized | years |
| | DUE TO (c) Mesenteric Thrombosis, Acute | 5 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

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|--|---|--|--|
| 19. WAS AUTOPSY PERFORMED? YES <input 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 a.m. p.m. Month, Day, Year | | | |

| | | | | |
|---|--|--|-------------------------|--------------------------|
| 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 12/17/59 to 12/19/59 and last saw her him alive on 12/19/59 | COUNTY Butler | STATE Missouri |
| 21. I attended the deceased from 6:00 P. M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | |

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|--|---|--|-----------------------------------|
| 22a. SIGNATURE <i>A.L. May, Jr.</i> (Degree and title) A. L. May, Jr., M.D. | | 22b. ADDRESS Poplar Bluff, Missouri | 22c. DATE SIGNED 1/5/60 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 12/23/59 | 23c. NAME OF CEMETERY OR CREMATORY Jacksonville Mausoleum Jacksonville, Ill. | |
| 24. FUNERAL DIRECTOR Frank-Cotrell Chapel, Poplar Bluff, Mo | 25. DATE RECD. BY LOCAL REG. 1/9/60 | 26. REGISTRAR'S SIGNATURE <i>R. M. ...</i> | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 26 1954

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 Edgar W. Lafflood

Licensed Embalmer No. 339K

P. O. Address Peplaw Bluff

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.

APR 26 1954