

I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-007074

FILED VS. MAR 7 1960

383

Primary Registration District No. 5655

Registrar's No. 187

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mt. Vernon</u>		Length of stay in 1b <u>14 days</u>		c. CITY OR TOWN <u>Sedalia</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>Mo. State Sanatorium</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>420 W. Cooper</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Lewis</u> Middle <u>B.</u> Last <u>Franklin</u>				4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1960</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1-27-92</u>		9. AGE (last birthday) <u>68</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Custodian</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>Benjamin Franklin</u>				13b. MOTHER'S MAIDEN NAME <u>Rachel Walls</u>				14. NAME OF HUSBAND OR WIFE <u>Josephine Franklin</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>495-36-6007</u>		17. INFORMANT Address <u>San. records, Mo. State Sanatorium, Mt. Vernon 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>Plasma Cell Myeloma</u>										INTERVAL BETWEEN ONSET AND DEATH <u>?</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) _____			
DUE TO (c) _____										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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		COUNTY _____ STATE _____					
21. I attended the deceased from <u>2-17-60</u> , to <u>3-2-60</u> and last saw her him alive on <u>3-2-60</u> Death occurred at <u>7:15 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>J. Lewis Gata MD</u>						22b. ADDRESS <u>Mt. Vernon, Mo.</u>				22c. DATE SIGNED <u>3-2-60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>3-2-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill Annex</u>				23d. LOCATION (City, town, or county) (State) <u>Sedalia, Mo.</u>					
24. FUNERAL DIRECTOR ADDRESS <u>Alvin Roberts 410 W Cooper</u>						25. DATE RECD. BY LOCAL REG. <u>3-2-60</u>		26. REGISTRAR'S SIGNATURE <u>H. H. [Signature]</u>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

MAR 11 1960

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

Student _____
Signature of Student Embalmer

Signed *Rue O. Hand*

Licensed Embalmer No. *4243*

P. O. Address *Sedalia*

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.