

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042005

FILED VS NOV 23 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5622 STATE FILE NUMBER

INDEXED

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. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>1 YEARS</b>	c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOSEPH'S HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>12 EAST 32ND TERRACE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>MINNIE E. FRANKE</b>			4. DATE OF DEATH Month Day Year <b>NOVEMBER 5 1960</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/17/87</b>	9. AGE (last birthday) <b>73</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	11. BIRTHPLACE (City and state or country) <b>DAVIS COUNTY, MO.</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		
13a. FATHER'S NAME <b>IZAAC ROBINSON</b>		13b. MOTHER'S MAIDEN NAME <b>ANNIE C. LINVILLE</b>		14. NAME OF HUSBAND <b>J. M. FRANKE</b>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>495-03-7397</b>	17. INFORMANT <b>MRS. RUTH BURG CAMERON, MISSOURI</b> Address: <b>228 SOUTH LOCUST</b>
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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: IMMEDIATE CAUSE (a) <b>Peritonitis Acute</b> <b>Perforation, Splenic Flexure of Colon</b> <b>from Ulcerating Carcinoma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>80 hours</b> <b>?</b>
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)		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

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 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
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21. I attended the deceased from **Nov 1 - 1960** to **Nov 4 1960** and last saw her alive on **Nov 4 - 1960**  
Death occurred at **6:25 A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Christ Broyles MD</i> (Decease or title)	22b. ADDRESS <b>1232 Professional Bldg</b>	22c. DATE SIGNED <b>11-5-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>NOV. 8, 1960</b>	23c. NAME OF CEMETERY OR PLACE OF INTERMENT <b>ARLINGTON NATIONAL CEMETERY FORT MYERS VIRGINIA</b>

24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS KANSAS CITY, MO.</b> ADDRESS <b>1331 BRUSH CREEK</b>	25. DATE RECD. BY LOCAL REG. <b>11-8-60</b>	26. REGISTRAR'S SIGNATURE <i>H. L. Dwyer</i>
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BY AFFIDAVIT OF **Christ H. Broyles** MEDICAL CERTIFICATION DOCUMENT

**STATEMENT BY LICENSED EMBALMER**

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 Basil J. [Signature]

Licensed Embalmer No. 472

P. O. Address A.C. [Signature]

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