

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-039768

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 324 Primary Registration District No. 6093 Registrar's No. 190

STATE FILE NUMBER

FILED OCT 23 1961

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall Township</u>		Length of stay in 1b <u>Hours</u>	c. CITY OR TOWN <u>Marshall</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>4 miles south of Marshall</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>518 North Drive</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Murrell</u> Last <u>Franklin</u>			4. DATE OF DEATH Month <u>October</u> Day <u>16th</u> Year <u>1961</u>

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>12-21-1913</u>	9. AGE (last birthday) <u>47</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Houstonia, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Clarence B. Franklin</u>	13b. MOTHER'S MAIDEN NAME <u>Lillie Martin</u>	14. NAME OF HUSBAND OR WIFE <u>Ona Mae Franklin</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	17. INFORMANT <u>518 North Drive Mrs John M. Franklin, Marshall, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure, Acute</u> DUE TO (b) <u>Poison - type undetermined</u> DUE TO (c) <u>(Probably cyanide)</u>		INTERVAL BETWEEN ONSET AND DEATH
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 type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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>Self inflicted</u>
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month <u>10</u> Day <u>16</u> Year <u>61</u>		

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 <u>Marshall</u> COUNTY <u>Saline</u> STATE <u>MO</u>
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>Dr. Upsher</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>Kansas City - Mo</u>	22c. DATE SIGNED <u>10/18/61</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-19-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ridge Park cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Marshall, Missouri</u>
24. FUNERAL DIRECTOR <u>Campbell-Lewis, Marshall, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>10-19-61</u>	26. REGISTRAR'S SIGNATURE <u>Carl S. Read</u>

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

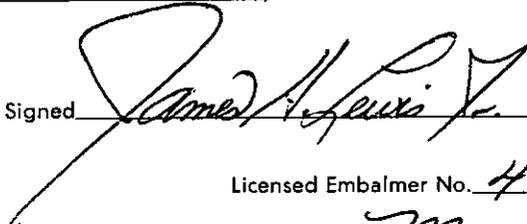
OCT 31 1961

FEB 7 1962

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 

Licensed Embalmer No. 4709

P. O. Address Marshall, W. Va.

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.