

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-042050

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 442 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 19 1962

1. PLACE OF DEATH a. COUNTY <u>Cole</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jefferson City</u> Length of stay in lb <u>2 Days</u>		c. CITY OR TOWN <u>New Bloomfield</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. Mary's Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>August Charles Frank</u>			4. DATE OF DEATH <u>Nov. 11 1962</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>9/8/1914</u>	9. AGE (last birthday) <u>48</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>State Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restraunt + Motel</u>		11. BIRTHPLACE (City and state or country) <u>Cole County</u>	

12. CITIZEN OF WHAT COUNTRY <u>USA.</u>		13a. FATHER'S NAME <u>Wm F. Frank</u>		13b. MOTHER'S MAIDEN NAME <u>Kathine Schulte</u>		14. NAME OF HUSBAND OR WIFE <u>Virgie. Frank</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>Mrs A.C. Frank New Bloomfield</u> Address	
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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 <u>48 hrs</u>
IMMEDIATE CAUSE (a) <u>Laceration of Both Lungs</u>			
DUE TO (b) <u>Multiple Fractured Ribs</u>			
DUE TO (c) <u>+ Clavicles</u>			
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 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>auto accident</u>
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20c. TIME OF INJURY <u>5:45 p.m.</u> Hour <u>Nov 8 1962</u> Month, Day, Year
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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.) <u>Highway</u>	20f. CITY, TOWN, OR LOCATION <u>New Bloomfield</u> COUNTY <u>Callaway</u> STATE <u>MO.</u>
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21. I attended the deceased from 11/8/62 to 11/11/62 and last saw him alive on 11/10/62
Death occurred at 12:15 A on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Francis J. Mead M.D.</u>	22b. ADDRESS <u>Jeff. City, Mo.</u>	22c. DATE SIGNED <u>11/13/62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Nov 14 - 62</u>	23c. PLACE OF BURIAL OR CREMATION <u>Church of God</u>	23d. LOCATION (City, town, or county) (State) <u>Mary's Home MO</u>
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24. FUNERAL DIRECTOR <u>Claypool Service</u> ADDRESS <u>New Bloomfield</u>	25. DATE RECD. BY LOCAL REG. <u>15 November 1962</u>	26. REGISTRAR'S SIGNATURE <u>R. Harrison Dr. Richter Dep</u>
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(Licensed Embalmer's Statement on Reverse Side)

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DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

NOV 22 1962

NOV 20 1962

DEC 19 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 *Libby Claypool*

Licensed Embalmer No. 4412

P. O. Address New Bloomfield
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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.