

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Greene

Township _____

Village _____

City Springfield (NO. _____ St. _____ Ward _____)

Registration District No. 318

Primary Registration District No. 2001

File No. 35988

Registered No. 614

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Harold Franklin

PERSONAL AND STATISTICAL PARTICULARS

SEX M. COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(If wife the word)

DATE OF BIRTH Nov 26, 1910
(Month) (Day) (Year)

AGE 3 yrs. 0 mos. 2 ds. IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) O = O

BIRTHPLACE (City or town, State or foreign country) Springfield, Mo.

NAME OF FATHER Albert M Franklin

BIRTHPLACE OF FATHER (City or town, State or foreign country) Greene Co. Mo.

MAIDEN NAME OF MOTHER Cordia Franklin

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Wright Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A M Franklin

(ADDRESS) 902 W Locust

Filed Nov 29, 1913 D W Smith
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov 28, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 27, 1913, to Nov 28, 1913, that I last saw him alive on Nov 28, 1913, and that death occurred, on the date stated above, at 3A m.

The CAUSE OF DEATH* was as follows:
Acute Indigestion

118C
86 (Duration) _____ yrs. _____ mos. _____ ds.

Contributory Convulsions
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) S. F. Freeman M. D.
Nov 28, 1913 (Address) Springfield Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RESIDENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Green Lawn DATE OF BURIAL Nov 29, 1913

UNDERTAKER W J Major ADDRESS Springfield

All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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City Springfield (NO. _____)

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Harold Franklin

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED S
(Write the word)

DATE OF DEATH 11-28-1913
(Month) (Day) (Year)

DATE OF BIRTH _____ (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 11-27-1913 to 11-28-1913
that I last saw him live on 11-28-1913
and that death occurred, on the date stated above, at 3 A m.

AGE _____ If LESS than 1 day, _____ hrs or _____ min

The CAUSE OF DEATH* was as follows:
Acute Indigestion
Esophageal fever caused by the indigestion
Stomach and bowels overworked
with acute indigestible food.

OCCUPATION (a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

Contributory Convulsions
(SECONDARY) Caused by Eating Walnuts Candy
(Signed) S. F. Freeman M.D.
11-28-1913 (Address) Springfield Mo

BIRTHPLACE (City or town, State or foreign country) _____

NAME OF FATHER _____

BIRTHPLACE OF FATHER (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs _____ mos _____ ds. In the State _____ yrs _____ mos _____ ds.

(Informant) _____

Where was disease contracted If not at place of death? _____

(ADDRESS) _____

Former or usual residence _____

Filed 11-29-1913 G. C. W. Smith REGISTRAR

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____

UNDERTAKER _____ ADDRESS _____

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

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