

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

Do not use this space.

8756

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City St. Louis mo (No. 4174) Fairfax Ave St. _____ Ward _____

File No. _____
 Registered No. **2429**
 St. _____ Ward _____

2. FULL NAME John Franklin
 (a) Residence. No. 4174 Fairfax St., 11 Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male **4. COLOR OR RACE** Coed **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Single
 (write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1908-1-20

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
21 | 1 | 2

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Chauffeur
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
 (STATE OR COUNTRY) Doughlessville Texas

10. NAME OF FATHER Treman Franklin

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
 (STATE OR COUNTRY) Doughlessville Texas

12. MAIDEN NAME OF MOTHER Ella Hunt

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
 (STATE OR COUNTRY) Texas

14. INFORMANT Ella Smith
 (Address) 4174 Fairfax Ave

15. FILED 1929 20 32 May C. Stanley
 REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 22 1929
17. I HEREBY CERTIFY That I attended deceased from July 28, 1928 to Feb 22, 1929
 that I last saw him alive on Feb 22, 1929, and that death occurred, on the date stated above, at _____ A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho Pneumonia (Primary)
81A
107A 130A
about (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) transverse myelitis
about (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED unborn
 IF NOT AT PLACE OF DEATH: ut b

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Lab. Clinical & Lab.
 (Signed) H.B. Howell M. D.
 , 19 (Address) 450. Conestoga

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Washington Park **DATE OF BURIAL** Feb. 24 1929

20. UNDERTAKER A.L. Beal, Dend Co. **ADDRESS** 2726 Lucas

N. B.—Every item of 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.

100
2
2
2

