AUG 18

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

REC'D AUG 23 1939

Registration District No. 784

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26926

Primary Registration District No. 113

Registrar's No. 1468

1. PLACE OF DEATH: 3

(a) County St. Louis

(b) City or town Rural St. Ferdinand
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Bellefountaine & Church Rd.,
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Mo. (b) County St. Louis

(c) City or town Florissant
(If outside city or town limits, write "RURAL")

(d) Street No. Route I, Box306
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME 652 John J. Franke

3. (b) If veteran, name war Worlds War

3. (c) Social Security No. None

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Laura Franke

6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased Dec. (Month) 26, (Day) 1896. (Year)

8. AGE: Years	Months	Days	If less than one day
42	7	21	..... hr. ..... min.

9. Birthplace ..... (City, town, or county) Mo. (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Joseph Franke
13. Birthplace ..... (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Elizabeth Oxmann
15. Birthplace ..... (City, town, or county) Mo. (State or foreign country)

16. (a) Informant's own signature Laura Franke

(b) Address Route I Box306, Florissant, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. (Month) 19/39 (Day) (Year)

(c) Place: burial or cremation St. Ferdinand Cem.,

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodiamont Ave.

19. (a) AUG 18 1939 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 16 year 1939 hour 8 minute 30A.M.

21. I hereby certify that I attended the deceased from ....., 19...., to ....., 19....; that I last saw h..... alive on ....., 19....; and that death occurred on the date and hour stated above.

Immediate cause of death ..... Duration

Asphyxiation from Methane (marsh gas) while repairing a

Due to well 8/16/39

Due to 178

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Hemorrhages of pleura

Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence August 16, 1939

(c) Where did injury occur? St. Ferdinand Twp. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Farm (Specify type of place)

707

While at work? yes (e) Means of injury gassed

23. Signature John S. Cornell (M.D. or other)

Address Coroner of St. Louis County, Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Jas. W. Clark

Licensed Embalmer No. I66I

P. O. Address II25 Hodiamont Ave.

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 this body is not embalmed, above space should be left blank.