

1000
Registration District No. **1000**

Primary Registration District No. _____

Registrar's No. **7614**

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. John's Hospital
(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)

3. (a) PRINT FULL NAME James William Franklin⁶⁵²

3. (b) If veteran, name war Nil 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Nil

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased September 5, 1931.
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>7</u>	<u>11</u>	<u>26</u>	hr. _____ min.

9. Birthplace Polpar Bluff Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation School child

11. Industry or business _____

MOTHER FATHER { 12. Name James E. Franklin

13. Birthplace Mexico Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Edna Wells

15. Birthplace Doniphan Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature James E. Franklin

(b) Address 3973 Sarpy St.,

17. (a) Removal (b) Date thereof 9/3/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Poplar Bluff Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.,

19. (a) SEP 2 1939 (b) _____
(Date received for record) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
(c) City or town St. Louis 18
(If outside city or town limits, write "RURAL")
(d) Street No. 3973 Sarpy St.,
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Sept day 1
year 1939 hour 10 minute 00 A.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: Asphyxiation during
Cleft Palate Operation at
Duke's Johns Hosp. Sept 1 1939
about 10:00 AM
Due to Hospital

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations See Above.
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) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature [Signature] (M. D. or other) 9/3
Address Pr... Date signed 9/3

WHILE MAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1 X 1931

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

Robert W. Waple

Licensed Embalmer No. *1861*

P. O. Address

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.