

Registration District No. **547**

Primary Registration District No. **3029**

Registrar's No. **218**

1. PLACE OF DEATH:

(a) County Marion

(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Levering 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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion

(c) City or town Hannibal
(If outside city or town limit, write "RURAL")

(d) Street No. R.R. # 3
(If rural, give location)

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

3. (a) PRINT FULL NAME Frank William Closs **1120**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30
year 1940 hour 2 minute P. M.

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

21. I hereby certify that I attended the deceased from July 1-40
_____, 19____, to July 30, 1940.
that I last saw him alive on July 30, 1940
and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife Sarah Sexton Closs 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased July 19, 1872
(Month) (Day) (Year)

Immediate cause of death Emphysema Struck

Due to _____

Due to _____

8. AGE: Years 68 Months _____ Days 11 If less than one day
hr. _____ min. _____

Other conditions Prostate Enlargement
(Include pregnancy within 3 months of death)

9. Birthplace Adair County Missouri
(City, town, or county) (State or foreign country)

Major findings: Of operations _____

Of autopsy _____

10. Usual occupation Truck Gardner

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

11. Industry or business XX

(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? OWN

MOTHER FATHER { 12. Name John Closs **6**

13. Birthplace Germany **6**
(City, town, or county) (State or foreign country)

14. Maiden name Carolyn (Unknown)

15. Birthplace Germany **6**
(City, town, or county) (State or foreign country)

16. (a) Informant P.W. Closs

(b) Address 312 Beech St Hannibal Mo

17. (a) Burial (b) Date thereof 8/2/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lutz Cemetery, Youngs

18. (a) Signature of funeral director Carroll Smith

(b) Address 902 Broadway

19. (a) 8-1-40 (b) H. C. Fisher
(Date received local registrar) (Registrar's signature)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

(e) Means of injury _____

23. Signature W.E. Salmer (M. D. or other) _____
Address Hannibal Mo Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

X21492

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SEP 23 1940

681

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 Joseph J. Marsh
Licensed Embalmer No. 3932
P. O. Address Hannibal Missouri

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29067**
Registrar's No. **218**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **347**

Primary Registration District No. **3029**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Marion

(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

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

3. (a) PRINT FULL NAME Frank Wm Cross

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 68 Months _____ Days 11 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name (City, town, or county) (State or foreign country)

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

16. (a) Informant (b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

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

(d) Street No. _____ (If rural, give location)

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

20. DATE OF DEATH: Month July day 30 year 1976 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.
Immediate cause of death Surgical shock postatectomy

Due to hypertrophy of prostate
Due to prostate

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

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 Chas Salyer (M. D. or other) _____
Address Hannibal Mo Date signed _____

SUPPLEMENTAL

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

