

No. 2
11-10-39
1-17-39
X2143

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

33087

State File No. _____

FILED OCT 10 1940 84
Registration District No. _____

Primary Registration District No. 200

Registrar's No. 1801

1. PLACE OF DEATH:

(a) County St. Louis Post Park Missouri
(b) City or town Kinloch Pk.
(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 2
In this community 3 Years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Carol J. Franklin

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

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased May 5th 1937
(Month) (Day) (Year)

8. AGE: Years 3 Months 3 Days 27 If less than one day hr. _____ min. _____

9. Birthplace St. Louis Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation _____ 0

11. Industry or business _____ 1

12. Name Arnold Franklin

18. Birthplace St. Louis Missouri (State or foreign country)

14. Maiden name Robinson

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

16. (a) Informant Arnold Franklin

(b) Address 1121 A N 24 St.

17. (a) Burial (b) Date thereof Sep. 24th
(Burial, cremation, or removal) (Month) (Day) (Year)
Washing Park

18. (a) Signature of funeral director P. Z. Garner

(b) Address 2829 Washington

19. (a) SEP 24 1940 (b) R. M. ...
(Date recorded) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ST. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1121 A N 24 th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 21st
year 1940 hour 1 minute 0 M.

21. I hereby certify that I attended the deceased from 9-17-
1940 to 9-21- 1940
that I last saw her alive on 9-19- 1940
and that death occurred on the date and hour stated above.

Immediate cause of death acute intestinal inflammation
Due to Diets error
Due to 120 hr
Other conditions (Include pregnancy within 3 months of death) _____

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

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 _____
Signature R. M. ... (M. D. or other) _____
Date signed 24/40

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

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

Melvin Blackburn

Licensed Embalmer No.

3962

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.

1901-2-23