

10-10-40
X23159

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36511-6

Registrar's No. 53

Registration District No. F10

Primary Registration District No. 6016

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

1. PLACE OF DEATH:

(a) County Scottland

(b) City or town Memphis R.F.D.
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 2
(Specify whether years, months or days)

In this community all her life
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Scottland

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

(d) Street No. 0
(If rural, give location)

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

3. (a) PRINT FULL NAME Emily Colth Franklin

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 25 year 1940 hour 3 minute A.M.

21. I hereby certify that I attended the deceased from 11/15, 1937, to 10/22, 1940 that I last saw her alive on 10/22, 1940 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color White 6. (a) Single, widowed, married, divorced widow

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

7. Birth date of deceased April 7 1870
(Month) (Day) (Year)

Immediate cause of death Carcinoma of breast and right side

8. AGE: Years <u>70</u>	Months <u>6</u>	Days <u>18</u>	If less than one day hr. _____ min. _____
-------------------------	-----------------	----------------	--

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

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

10. Usual occupation Retired Housewife

11. Industry or business _____

12. Name Asa B. Pierce

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

14. Maiden name Emily Rathbun

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

Major findings: _____

Of operations _____

Of autopsy _____

16. (a) Informant Milo Franklin

(b) Address Memphis Mo

17. (a) Burial (b) Date thereof Oct 27-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lawn Ridge

18. (a) Signature of funeral director Beth Washburn

(b) Address Memphis Mo

19. (a) Nov. 9-1940 (b) E. Parrish
(Date received local registrar) (Registrar's signature)

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? _____ (e) Means of injury _____

23. Signature PTM Baker (M. D. or other) _____

Address Memphis Mo Date signed 10/26/40

57

RECEIVED

District Health Officer No. 10

District File Number 11-40-2157

Date Filed NOV 14 1940

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 Albert C Gerth

Licensed Embalmer No. 3689

P. O. Address Memphis Mo

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 365-11
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 810

Primary Registration District No. 6056

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

1. PLACE OF DEATH:

(a) County Scotland
(b) City or town Union
(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 _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME

Emily Colt Franklin

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color, or race w

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

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____

(Month) (Day) (Year)

8. AGE:

Years 70 Months 6 Days 18

If less than one day _____ hr. _____ min.

9. Birthplace _____

(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace _____

(City, town, or county) (State or foreign country)

14. Maiden name _____

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 25 year _____ hour _____ minute _____ M.

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

Immediate cause of death Carcinoma of breast and right ad
Facts as above stated as primary
Due to _____
Due to _____ 50

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

Major findings: Of operations _____

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 PTA Baker (M. D. or other) _____
Address Memphis mo Date signed 12/20/20

SUPPLEMENTARY

