

No. 2
11-10-39
5-17-39
I X21422

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **7181**

MAR 17 1941

Registration District No. **403** Primary Registration District No. **551-7**

Registrar's No.

18000
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

I. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
65th And Cambridge (R.F.D. No. 2)
(If not in hospital or institution, write street number or location)

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

In this community 30 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Rural Route No. 2 Kansas City, Mo.
(If outside city or town limits write "RURAL")

(d) Street No. 65th and Cambridge (R.F.D. No. 2)
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

8. (a) PRINT FULL NAME Mrs. Jennie Florence Frank

8. (b) If veteran, name war No

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 7 year 1940 hour 9 minute 30A.M.

4. Sex Female

5. Color or race white

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

6. (b) Name of husband or wife Henry Frank

6. (c) Age of husband or wife if alive 26 years

7. Birth date of deceased February 26 1868
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 10 1940 to June 7 1940
that I last saw him alive on June 7 1940
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>72</u>	<u>3</u>	<u>12</u>	hr. _____ min. _____

Immediate cause of death Coronary Occlusion 2 days

Due to Arterio Sclerosis 8 yrs

Due to Hypertension 8 yrs

Other conditions Diabetes Mellitus 12 yrs
(Include pregnancy within 3 months of death)

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

10. Usual occupation At Home

PHYSICIAN

Major findings:
Of operations 6

Of autopsy _____

Underline the cause to which death should be charged statistically.

11. Industry or business H

MOTHER FATHER

12. Name John Pierce

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

14. Maiden name Unknown Jones

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

16. (a) Informant Harold Frank

(b) Address 65th and Cambridge R.F.D. 2

17. (a) Cremation (b) Date thereof June 7, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

(c) Place: burial or cremation D. W. Newcomer's Sons Mortuary

18. (a) Signature of funeral director D. W. Newcomer

(b) Address 1401 Brush Creek Blvd.

19. (a) _____ (b) N. M. [Signature]
(Date received local registrar) (Registrar's signature)

(Specify type of place) _____ (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____

Address See Professional Bldg Date signed 6/7/40

Dr. Edward Hache
Professional Be
1-370

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 Emile M. Calhoun
Licensed Embalmer No. 3506
P. O. Address K. E. Mrs.

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.