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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 22 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 32518

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 2091

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

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0
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1. PLACE OF DEATH:

(a) County St Louis

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

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

(d) Length of stay: In hospital or institution 1 mo 17 days (Specify whether
In this community 19 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis 000 17 9

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

(d) Street No. 3427 Walnut St
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 1

3. (a) PRINT FULL NAME FRANKLIN, ERNESTINE

3. (b) If veteran, name war

3. (c) Social Security No. 4

4. Sex F3

5. Color or race N

6. (a) Single, widowed, married, divorced S O

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov (Month) 23 (Day) 1921 (Year)

8. AGE: Years 21 Months 9 Days 21 If less than one day hr. min.

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

10. Usual occupation Laundress

11. Industry or business

FATHER
12. Name Dan Franklin
13. Birthplace ? (City, town, or county) ? (State or foreign country)

MOTHER
14. Maiden name Mattie Jones
15. Birthplace ? (City, town, or county) ? (State or foreign country)

16. (a) Informant Hospital Record
(b) Address Robert Koch Hosp

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/43 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park Cem

18. (a) Signature of funeral director R. M. C. Green
(b) Address 3517 Cachelle Ave.

19. (a) (Date received by registrar) (b) E. J. McLaurin M.D. (Registrar's signature)

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MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Sept day 13
year 1943 hour 2 minute 0 A M.

21. I hereby certify that I attended the deceased from July 27, 1943, to Sept 13, 1943
that I last saw her alive on Sept 13, 1943
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulm. Tuberculosis	8 mo
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

13 b1

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Frank Cohen (M. D. ~~or other~~)

Address Robert Koch Hosp Date signed 9/13/43

(Licensed Embalmer's Statement on Reverse Side)

SEP 22 1943

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.....

Licensed Embalmer No. 1173

P. O. Address 3517 Laclede Ave

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.