DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 24, 1944

Registration District No. 1

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3000

State File No. 1877

Registrar's No. 9

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

1. PLACE OF DEATH:

(a) County Adair

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

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

(d) Length of stay: In hospital or institution 20 days (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CLARK 23

(c) City or town LURAY (If outside city or town limits, write "RURAL") 0

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

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

If yes, name country 1

3. (a) PRINT FULL NAME JOHN HENTY FRANKHOUSE ST

3. (b) If veteran, name war

3. (c) Social Security No. 707-07-6316

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of ~~husband~~ or wife EMMA MAE

6. (c) Age of ~~husband~~ or wife if alive 66 years

7. Birth date of deceased January (Month) 8 (Day) 1866 (Year)

8. AGE: Years 77 Months 11 Days 7 If less than one day hr. min.

9. Birthplace HANCOCK (~~City, town, or~~ county) ILLINOIS (State or foreign country) 1

10. Usual occupation Retired Crossing Flagman

11. Industry or business

FATHER
12. Name CHARLES ROSS
13. Birthplace unknown (City, town, or county) (State or foreign country) 9

MOTHER
14. Maiden name CATHRINE KEITH
15. Birthplace unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant John H. Frankhouse Jr

(b) Address Luray Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 19 1943 (Month) (Day) (Year)

(c) Place: burial or cremation Luray Cemetery

18. (a) Signature of funeral director Guth & Bookers

(b) Address Wyaconda, Mo

19. (a) 1/21/44 (Date received local registrar) (b) Mrs. J. Warner (Registrar's signature)

1049

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 15 year 1943 hour 9 minute 20 P M.

21. I hereby certify that I attended the deceased from November 26, 1943 to Dec 15, 1943 that I last saw him alive on Dec 15, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia — Duration 10 days

Due to Prostatic hypertrophy, obstruction & resultant pyelitis about 2 yrs

Due to ~~Card~~ 131a

Other conditions Cardiovascular, renal disease 20 yrs (Include pregnancy within 3 months of death)

Major findings:
Of operations None except punch removal of median bar of prostate
Of autopsy None

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 George E. Grim (M. D. or other) MD

Address Kirksville, Date signed 1-20-44

(Licensed Embalmer's Statement on Reverse Side)

JAN 26 1944

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. 1407

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.)

E 12-15-43
B 1-20-44

If this body is not embalmed, fact should be so stated above.