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ev. 5-17-39
P I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25644

Registration District No. 318 Primary Registration District No. 1005 Registrar's No. 7640

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Baptist O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 weeks (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County
(c) City or town Fredrickstown
(If outside city or town limits, write "RURAL")
(d) Street No. 507 W. Marcott
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

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3. (a) PRINT FULL NAME William Francis
3. (b) If veteran, name war No
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Millie
6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased May (Month) 27 (Day) 1880 (Year)
8. AGE: Years 65 Months 3 Days 2 If less than one day hr. min.
9. Birthplace (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Eliza Francis
FATHER 13. Birthplace (City, town, or county) Mo. (State or foreign country)
MOTHER 14. Maiden name Harriet
MOTHER 15. Birthplace (City, town, or county) ~~Ind~~ (State or foreign country)
16. (a) Informant Mrs Millie Frances
(b) Address Fredrickstown Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 1 45 (Month) (Day) (Year)
(c) Place: burial or cremation Fredrickstown, Mo
18. (a) Signature of funeral director Stanley Dixon Funeral Home
(b) Address Fredrickstown, Mo.
19. (a) SEP 1 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 29 year 1945 hour 1 minute 10 P.M.
21. I hereby certify that I attended the deceased from Aug 14, 1945, to Aug 29, 1945, that I last saw him alive on Aug 29, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to 94a	
Due to	
Other conditions (Include pregnancy within 3 months of death) prostatitis	

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? (Specify type of place)
While at work? (e) Means of injury
Signature J. E. Flenn (M. D. or other)
Address 958 Arcade Bldg Date signed Aug 29/45

(Licensed Embalmer's Statement on Reverse Side)

JAN 24 1955

7640

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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. 9472

P. O. Address 4911 Washington

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.