

FILED SEP 5 1945

Registration District No. _____

Primary Registration District No. 6076

Registrar's No. 2101

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis - Rural Wellston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Vincent's Sanitarium 6
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County COO
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 17
(d) Street No. 5210 Maffitt Ave
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MRS. JOSEPHINE FRANKLIN

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female / 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mr. Michael Franklin
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased December 3 1891
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
53 8 24 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Thomas Downs Ireland // (City, town, or county) (State or foreign country)

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

14. Maiden name Mary Foley

15. Birthplace Ireland // (City, town, or county) (State or foreign country)

16. (a) Informant Mr. Michael Franklin-Husband

(b) Address 5210 Maffitt Avenue,

17. (a) burial (b) Date thereof 8-30-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Int. Calvary Cemetery

18. (a) Signature of funeral director Sullivan Brothers,

(b) Address 2849 North Euclid Avenue,

19. (a) 8-28-45 (b) P. H. McArthur
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 27 year 1945 hour 10 minute 40 A.M.

21. I hereby certify that I attended the deceased from Aug. 15, 1945, to Aug 27, 1945; that I last saw her alive on Aug 27, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death pleurocarcinoma - primary in breast metastatic - lungs & brain
Duration 2 yrs.
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: 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 E. F. Jassin (M. D. or other)

Address Frisco Bldg Date signed 8/27/45

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

MOTHER FATHER

707

SEP 6 1945

SEP 25 1945

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 Robert L. Brinkman
Licensed Embalmer No. 3553
P. O. Address St. Louis, 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.