S. No. 2
M—5-42
v. 5-17-39
I X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JAN 26 1946

State File No. 2697

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 6

1. PLACE OF DEATH:

(a) County GREENE

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

(c) Name of hospital or institution: 1804 W. Atlantic (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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene

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

(d) Street No. 1804 W. Atlantic (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME John Rexford Franklin

3. (b) If veteran, name war UNK.

3. (c) Social Security No. 491-05-4964

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife Sarah Franklin

6. (c) Age of husband or wife if alive 20 years

7. Birth date of deceased July (Month) 22, (Day) 1877 (Year)

8. AGE: Years 68 Months 5 Days 1 If less than one day hr. min.

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

10. Usual occupation Painter

11. Industry or business Painter

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) UNK. (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) UNK. (State or foreign country)

16. (a) Informant Sarah Franklin
(b) Address 1804 W. Alantic, Sprd., Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1,6,46 (Month) (Day) (Year)
(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director J.W.Klingner & Co.
(b) Address Springfield, Missouri

19. (a) 1-4-46 (Date received local registrar) (b) W E Hardy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 3 year 1946 hour 12; minute 45 A.M.

21. I hereby certify that I attended the deceased from 12/11 1945 to 1-3 1946 that I last saw h. alive on JAN 2 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia — Duration 2 days

Due to Cardiac Asthma

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy no

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? no (Specify type of place)

While at work? (e) Means of injury

23. Signature O. F. Freeman (M. D. or other)

Address Springfield, Mo. Date signed 1/3/46

(Licensed Embalmer's Statement on Reverse Side)

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

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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.....Ray Rhodes

Licensed Embalmer No.....4071

P. O. Address.....Springfield

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.