

No. 2  
8-43  
17-59  
7X37823

FILED MAY 14 1947

Registration District No. \_\_\_\_\_

Primary Registration District No. 5417

Registrar's No. \$

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Rural (No. 2150)  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or (day)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin <sup>35</sup>

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

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

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Jacob F. Droke

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 30  
year 1947 hour 6 AM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 3-28-47  
19\_\_\_\_ to 3-30 1947  
that I last saw him alive on 3-28- 1947  
and that death occurred on the date and hour stated above.

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Celia Droke 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 8-19-1875  
(Month) (Day) (Year)

Immediate cause of death Heart trouble Duration Sudden

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions none  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day

71 7 11 hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

12. Name Wright Droke

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

14. Maiden name Rob. Knison

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant Brodie Droke

(b) Address \_\_\_\_\_

17. (a) Burial (b) Date thereof 4-1-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cade Cemetery

18. (a) Signature of funeral director W. Daniel Tunney

(b) Address Demuth, Mo.

19. (a) 4-16-47 (b) Bertha Karschne  
(Date received local registrar) (Registrar's signature)

Major findings: Of operations \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature W. Daniel Tunney (M. D. or other) \_\_\_\_\_  
Address Demuth, Mo. Date signed 4-1-47

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

RECEIVED

District Health Office No. 2,

District File Number 542-698

Date Filed 5-12-47

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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 Arthur S. McDaniel

Licensed Embalmer No. 2093

P. O. Address Seneca 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. May  
Registrar's No. 8

Registration District No. 103

Primary Registration District No. 5417

1. PLACE OF DEATH:

(a) County Dunklin  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME

Jacob F Drake

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased. Aug-19  
(Month) (Day) (Year)

8. AGE: Years 71 Months 7 Days 7 If less than one day, hr. \_\_\_\_\_ min \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 20  
year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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?  
\_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

13035