

0. 2  
4-41  
7-39  
X29484

FILED AUG 29 1947  
Registration District No. **73**

Primary Registration District No. **4153**

Registrar's No. **75**

1. PLACE OF DEATH:

(a) County **Dale**

(b) City or town **Rural - Center**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Lockwood Memorial Hospital**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **12 hours**  
(Specify whether)

In this community **Lifetime - 26 years**  
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Dale** **29**

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

(d) Street No. **5 miles N. W. of Greenfield**  
(If rural, give location)

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

If yes, name country **No**

3. (a) PRINT FULL NAME **LILLY LORENE FRANKLIN**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **No**

4. Sex **Female**

5. Color or race **White**

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

6. (b) Name of husband or wife **W. S. Franklin**

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

7. Birth date of deceased **May 13 1921**  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<b>26</b>	<b>3</b>	<b>1</b>	hr. min.

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

10. Usual occupation **Home**

11. Industry or business

MOTHER FATHER

12. Name **Oellie Woods**

13. Birthplace **No Record** **9**  
(City, town, or county) (State or foreign country)

14. Maiden name **Bulah Cook**

15. Birthplace **No Record** **9**  
(City, town, or county) (State or foreign country)

16. (a) Informant **W. S. Franklin**

(b) Address **R.F.D. Greenfield, Mo.**

17. (a) **Burial** (b) Date thereof **8-17-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wetzel Cemetery**

18. (a) Signature of funeral director **Sally E. Samsberry**

(b) Address **Greenfield Mo.**

19. (a) **8-18-47** (b) **Ed R. Weir**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **14**  
year **1947** hour **1** minute **30** P. M.

21. I hereby certify that I attended the deceased from **Aug 1 47**  
19 **Aug 14 1947**  
and that death occurred on the date and hour stated above.

Immediate cause of death **placenta praevia totalis (hemorrhage due to shock)**

Due to **shock**

Due to

Other conditions (Include pregnancy within 3 months of death) **146 A**

Major findings: Of operations

Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 **0**

23. Signature **J. P. Corvan** (M. D. or other)

Address **Greenfield Mo.** Date signed **8-17-47**

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

RECEIVED

District Health Officer No. 6,

District File Number 847-916

Date Filed AUG 27 1947

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.....

*Sam E. Senseney Jr*

Licensed Embalmer No. 4099

P. O. Address Greenfield Ma

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.

Sept 1947

Registration District No. 93

Primary Registration District No. H/13-3

Registrar's No.

1. PLACE OF DEATH:

(a) County Dade  
(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

Lillys L. Franklin

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

4. Sex F 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 May 13  
(Month) (Day) (Year)

8. AGE: Years 26 Months 3 Days 1 If less than one day hr. min.

9. Birthplace. (City, town, or county) (State or foreign country) No

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)  
(c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address

19. (a) (Date received local registrar) (b) (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 Aug Day 14 Year 1947 Hour 12 minute 00 M.

21. I hereby certify that I attended the deceased from 12 to 12, 1947; that I last saw him alive on Aug 13 and that death occurred on the date and hour stated above. Immediate cause of death Asphyxia

Duration

Due to Asphyxia  
Due to Asphyxia

Other conditions (include pregnancy within 3 months of death)  
Delivered before death  
Major findings: 20 months gestation  
infant, living and viable  
Or 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) (e) Means of injury

23. Signature J. O. Carson (M. D. or other)  
Address Greenfield mo Date signed 9-7-47

SUPPLEMENTARY

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

27192