

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **19093**BIRTH NO. _____ REG. DIST. NO. **116** PRIMARY REG. DIST. NO. **3020** Registrar's No. **101**

1. PLACE OF DEATH a. COUNTY Franklin.		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Franklin	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Washington.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Union	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Francis Hospital.		d. STREET ADDRESS (If rural, give location) Main & Lincoln St.	

3. NAME OF DECEASED (Type or Print) a. (First) George	b. (Middle) Henry	c. (Last) French	4. DATE OF DEATH (Month) (Day) (Year) June 20th, 1949.
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Apr. 25, 1876.	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months 1 Days 25	IF UNDER 12 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Shoe Cobbler.	10b. KIND OF BUSINESS OR INDUSTRY x	11. BIRTHPLACE (State or foreign country) St. Clair, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME James Thomas French.	13b. MOTHER'S MAIDEN NAME Unknown Mary Ann Renfroe.	14. NAME OF HUSBAND OR WIFE Lydia V. French.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.	16. SOCIAL SECURITY NO. None.	17. INFORMANT'S SIGNATURE OR NAME Mrs. Alvie C. Owens	ADDRESS Washington, Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Hepatic abscess	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hepatic abscess		INTERVAL BETWEEN ONSET AND DEATH 10 days
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		583X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from **June 16, 1949**, to **June 20, 1949**, that I last saw the deceased alive on **June 19, 1949**, and that death occurred at **4:15 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Frank G. Mays M.D.	23b. ADDRESS Washington, Mo	23c. DATE SIGNED 6-20-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial.	24b. DATE June 22, 1949	24c. NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery	24d. LOCATION (City, town, or county) (State) Washington, Mo.
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DATE REC'D BY LOCAL REG. June 21, 1949	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE 990 Hilburg & Vitt Inc.	ADDRESS Washington, Mo.
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RECEIVED JUN 27 1949
District Health Officer No. 9,
District File Number

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.....

Student Embalmer No.

working under my personal supervision.

Signed.....
Student Embalmer

11-7-49

Signed.....

W. Sieber

Licensed Embalmer No.

2387

P. O. Address

Washington, D.C.

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.