

Dr. Health,
, & Welfare
S. Public
th Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35807

STATE FILE NUMBER

FILED NOV 5 1957

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4861

S. 300
v. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Graham Asher

| | | | | | |
|---|------------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Jackson | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hosp. | | Length of stay in 1b 59 years | d. STREET ADDRESS (If outside, give location) 5729 Virginia | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Albertt Middle S Last Franse | | | 4. DATE OF DEATH Month Oct. Day 18 Year 1957 | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 5, 1879 | | 9. AGE (In years last birthday) 78 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired transfer co. Arrow Delivery Co. Cass County Mo. | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Mo. | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13a. FATHER'S NAME William P. Franse | | 13b. MOTHER'S MAIDEN NAME Nancy Crosswhite | | 14. NAME OF HUSBAND OR WIFE Manta D. Franse | |
| 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 Address Manta Franse 5729 Virginia | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 mos. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | |
| DUE TO (b) Coronary Artery Sclerosis & Thrombosis - 5 years | | | | | |
| DUE TO (c) General Vascular Sclerosis - 5 years | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Auricular Fibrillation - 4201 | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | | |
| 20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____ | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from Nov. 15, 1957 to Oct. 18, 1957 and last saw ^{her} _{him} alive on Oct. 18, 1957 Death occurred at 10 a.m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) Graham Asher M.D. | | 22b. ADDRESS 1220 Professional Bldg. Kansas City, Mo. | | 22c. DATE SIGNED 10-19-57 | |
| 23a. BURIAL, CREMATION, ETC. (Specify) Buried | | 23b. DATE 10-21-1957 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah | |
| 23d. LOCATION (City, town, or county) Kansas City, Missouri | | | | | |
| 24. FUNERAL DIRECTOR Stine & McClure | | ADDRESS Kansas City, Mo. | | 25. DATE RECD. BY LOCAL REG. 10-21-57 | |
| | | | | 26. REGISTRAR'S SIGNATURE Neva Minshall | |

(Licensed Embalmer's Statement on Reverse Side)

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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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Elmo D. Triplett*

Licensed Embalmer No. *4817*

P. O. Address *Kansas City, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.