MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

=61=033541
STATE FILE NUMBER

AMENDED

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 169

FILED SEP 25 1961

1. PLACE OF DEATH a. COUNTY Livingston

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Chillicothe — Length of stay in 1b: 1 hour

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chillicothe Hospital — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Grundy

c. CITY OR TOWN Laredo — Inside Limits: Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) ✓ — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: James Middle: Benjamin Last: Franklin

4. DATE OF DEATH Month: September Day: 19 Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 1/31/1907

9. AGE (last birthday): 54

IF UNDER 1 YEAR: Months 7 Days 18 — IF UNDER 24 HR: Hours ✓ Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher

10b. KIND OF BUSINESS OR INDUSTRY: School

11. BIRTHPLACE (City and state or country): Milan Mo

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Robert E. Franklin

13b. MOTHER'S MAIDEN NAME: Mary Susan Jones

14. NAME OF HUSBAND OR WIFE: Lorraine Franklin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of serv: ✓

16. SOCIAL SECURITY NO.

17. INFORMANT: Jim Franklin Address: Chillicothe Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 12 hr.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 Sept 19-61, to Sept 19-61 and last saw her/him alive on Sept 19-61

Death occurred at 11:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Joseph T. Gale (Degree or title) M.D.

22b. ADDRESS Chillicothe Mo

22c. DATE SIGNED 9-20-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 9/21/1961

23c. NAME OF CEMETERY OR CREMATORY Oak Wood Cemetery

23d. LOCATION (City, town, or county) Milan (State) Mo

24. FUNERAL DIRECTOR ADDRESS: E.J. Robertson Funeral Home Laredo Mo

25. DATE RECD. BY LOCAL REG. Sep 20, 1961

26. REGISTRAR'S SIGNATURE Annalee Taylor

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

SEP 26 1961

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 [illegible]

Licensed Embalmer No. 4388

P. O. Address Laredo 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.