

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-014677

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 60

STATE FILE NUMBER

**FILED APR 12 1963**

DO NOT WRITE ON THIS STUB

AMENDED

|                |              |
|----------------|--------------|
| VS 300         | DATE AMENDED |
| Rev. 4/59      |              |
| 1 <u>10 85</u> |              |
| 2 <u>10 85</u> |              |
| 3              |              |
| 4 <u>0</u>     |              |
| 5 <u>1</u>     |              |
| 6              |              |
| 7 <u>0</u>     |              |
| 8 <u>2</u>     |              |
| <u>9331X</u>   |              |
| 10             |              |
| 11             |              |
| 12 <u>91-0</u> |              |
| 13 <u>1-0</u>  |              |

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Vernon</u>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Vernon</u>                            |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Nevada</u> Length of stay in 1b   |   | c. CITY OR TOWN <u>Nevada</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location) <u>Nevada Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   | d. STREET ADDRESS <u>1825 North Main</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>M.</u> Last <u>FRANKLIN</u>   |   | 4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1963</u>   |  |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>Wh</u>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>          | 8. DATE OF BIRTH <u>5-6-1883</u>                             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hospital attendant</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>   | 9. AGE (last birthday) <u>79</u>                             |
| 11. BIRTHPLACE (City and state or country) <u>Piedmont, Missouri</u>   |   | 12. CITIZEN OF WHAT COUNTRY <u>USA</u>   |  |
| 13a. FATHER'S NAME   |   | 13b. MOTHER'S MAIDEN NAME  | 14. NAME OF HUSBAND OR WIFE <u>Stella Franklin</u>           |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>   |   | 16. SOCIAL SECURITY NO. <u>[REDACTED]</u>  |  |
| 17. INFORMANT <u>Mrs. Stella Franklin, 1825 N. Main, Nevada, Mo.</u>   |   | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRAGE</u>   |   | INTERVAL BETWEEN ONSET AND DEATH <u>17 Hrs.</u>  |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m. Month, Day, Year _____  |   |  |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input 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 <u>Mar 31, 1963</u> to <u>Mar 31, 1963</u> and last saw her/him alive on <u>Mar 31, 1963</u><br>Death occurred at <u>4:55 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. |   |  |  |
| 22a. SIGNATURE (Degree or title) <u>James J. Proctor, M.D.</u>   |   | 22b. ADDRESS <u>Moore Building, Nevada, Mo.</u>  | 22c. DATE SIGNED <u>4-4-63</u>                               |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE <u>April 3, 1963</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>Moore Cemetery</u>   | 23d. LOCATION (City, town, or county) <u>Nevada Missouri</u> |
| 24. FUNERAL DIRECTOR <u>Ferry Funeral Home</u> ADDRESS <u>Nevada, Missouri</u>   |   | 25. DATE RECD. BY LOCAL REG. <u>4-10-'63</u>   | 26. REGISTRAR'S SIGNATURE <u>Anna E. Jolly</u>               |

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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 Ray K. Ireland

Licensed Embalmer No. 5054

P. O. Address Nevada, 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.