

FILED APR 24 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14216

State File No.

BIRTH NO. _____ REG. DIST. NO. 297 PRIMARY REG. DIST. NO. 3057 Registrar's No. 14

0891
1

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

1. PLACE OF DEATH a. COUNTY <u>Ray</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Richmond</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Richmond</u>	
c. LENGTH OF STAY (in this place) <u>86 days</u>		d. STREET ADDRESS (If rural, give location) <u>308 North Thornton</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>308 North Thornton</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>FRANCES</u> b. (Middle) <u>ANN</u> c. (Last) <u>BOHANNON</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 22, 1950</u>
----------------------------------------------------------------------------------------------------------------------	--	--	-------------------------------------------------------------------

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>September 13, 1863</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u>	IF UNDER 1 HRS. Hours <u>0</u> Min. <u>0</u>
-------------------------	----------------------------------	--------------------------------------------------------------------------	-----------------------------------------------	----------------------------------------------	--------------------------------------------------	-------------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Never employed</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Never employed</u>	11. BIRTHPLACE (State or foreign country) <u>Richmond, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
----------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------

13a. FATHER'S NAME <u>Richard Bohannon</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Frances Morris</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
-----------------------------------------------	----------------------------------------------------------	--------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Howard Shirley</u>	ADDRESS <u>Richmond, Missouri</u>
-------------------------------------------------------------------------------------------------------------------------	----------------------------------------	------------------------------------------------------------	--------------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 yrs.</u> <u>10 yrs = 4530</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchopneumonia</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cachexia</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	-------------------------------------------------------------------------------------

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)
------------------------------------------	------------------------------------------------------------------------------------------	-------------------------------------------------

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
-------------------------------------------------	--------------------------------------------------------------------------------------------------------	----------------------------

22. I hereby certify that I attended the deceased from May 6, 1949, to March 22, 1950, that I last saw the deceased alive on March 21, 1950, and that death occurred at 3:55 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>F.R.C. Johnson D.M.D.</u>	23b. ADDRESS <u>Richmond, Mo</u>	23c. DATE SIGNED <u>3/25/50</u>
------------------------------------------------------------------	-------------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>March 23, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Sumner Station</u>	24d. LOCATION (City, town, or county) (State) <u>Richmond, Missouri</u>
------------------------------------------------------------	------------------------------------	-------------------------------------------------------------	----------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. <u>Mar. 27-1950</u>	REGISTRAR'S SIGNATURE <u>W. C. Jackson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Hill Funeral Home</u>	ADDRESS <u>308 North Thornton Richmond, Mo</u>
-------------------------------------------------	-----------------------------------------------	--------------------------------------------------------------------	---------------------------------------------------

RECEIVED 4-3-50

District Health Officer No. _____

District File Number _____

Date Filed 4-22-50

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 _____
Student Embalmer

Signed *George P. Hele*

Licensed Embalmer No. 4064

P. O. Address *St. Louis, Missouri*

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.