

MEDICAL CERTIFICATION	LOCAL DEPARTMENT'S NUMBER <i>177</i>	
	1. NAME OF DECEASED <i>FRANKIE ANN</i>	
	2. PLACE OF DEATH A. COUNTY <i>OK</i>	
	B. CITY, TOWN, OR VILLAGE C. LOCATION <i>FLANK</i>	
	D. NAME OF HOSPITAL <i>Presbyterian</i>	
	3. DATE OF DEATH Month <i>March</i> Day <i>November</i>	
	6. SOCIAL SECURITY NUMBER <i>632-14-6829</i>	
	12. DATE OF BIRTH Month <i>September</i>	
	14. BIRTHPLACE (State) <i>West Plains, Mo</i>	
	17. NAME OF DECEASED <i>Thosae Angie</i>	
	20. CAUSE OF DEATH PART I: DEATH WAS NATURAL	
	<p>Question: Was any of the following things done to the body during the last 24 hours before death?</p> <p>Part II: Other things contributing to death (if the deceased changed his mind in 1 hour)</p>	
	23. Was death directly or indirectly caused by any of the following?	
	25. TIME OF INJURY Hour <i>11:00</i> Day <i>Monday</i>	
	26. CERTIFICATE <i>Scott</i>	
28. RESERVED FOR RECORD		
<p>29. DATE AND TIME OF REPORT Date <i>March 11</i> Time <i>11:00</i></p>		
31. DATE RECEIVED		