

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1927
4

1. PLACE OF DEATH

County Wasson Registration District No. 875
 Township Washington Primary Registration District No. 6102
 City Wasson (No.) St. Ward (....)

File No.
 Registered No. 79

2. FULL NAME

E. D. Frost
 (a) Residence. No. State Hospital St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 30 yrs. 4 mos. 5 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wasson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7 18 38
 7. AGE YEARS 89 MONTHS 6 DAYS 4 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work 1012
 (b) General nature of industry, business, or establishment in which employed (or employee).
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Kentucky (STATE OR COUNTRY)

10. NAME OF FATHER H. B. Frost
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kentucky (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Mary Thomas
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Kentucky (STATE OR COUNTRY)

14. INFORMANT E. D. Frost (Address) Wasson

15. FILED 5/19/27 E. D. Frost REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-3-1927
 17. I HEREBY CERTIFY, That I attended deceased from 4-1-1927, to 4-3-1927, that I last saw him alive on 4-2-1927, and that death occurred, on the date stated above, at 7:00 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy
Stroke
 CONTRIBUTOR (SECONDARY) W. A. T. (duration) yrs. mos. ds.

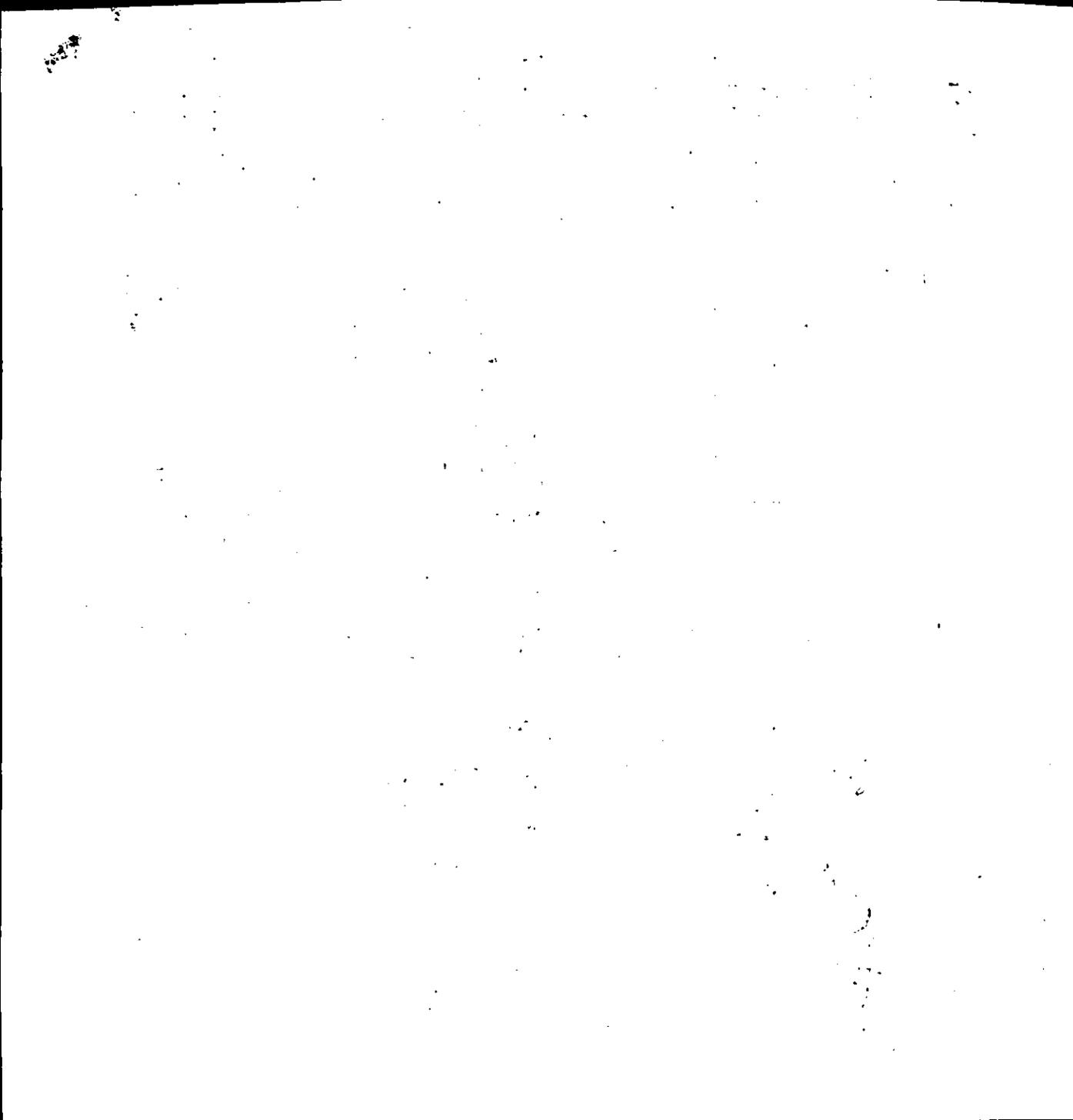
18. WHERE WAS DISEASE CONTRACTED X
 IF NOT AT PLACE OF DEATH...
 DID AN OPERATION PRECEDE DEATH? no DATE OF...
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? none
 (Signed) G. B. Darrell, M. D.
4/5 .1927 (Address) Nevada, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Wasson, Mo. DATE OF BURIAL 4/3/27

20. UNDERTAKER Wasson, Mo. ADDRESS

PARENTS



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Harrison Registration District No. 875 File No.
 Township Washington Primary Registration District No. 6162 Registered No. 79
 City E. D. Pratt St. Ward)

2. FULL NAME

(a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 19-30-1883

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>89</u>	<u>.6</u>	<u>4</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) (duration) yrs. mos. ds.
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 6/21 1928 E. G. King REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 3 19 27

17. I HEREBY CERTIFY That I attended deceased from 19....., 19..... that I last saw h..... alive on 19....., and that death occurred, on the date stated hereon, m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) M. D. , 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-13974