OCT 26 1928

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

Do not use this space.

30770

1. PLACE OF DEATH
County Jackson — Registration District No. 403 — File No.
Township Brooking — Primary Registration District No. 5557 — Registered No.
City (No. St. Ward)

2. FULL NAME Andrew J. Frost
(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 62 yrs. mos. 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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 29-1841

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
87	✓	6	

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

9. BIRTHPLACE (CITY OR TOWN) New York City
(STATE OR COUNTRY) N. Y.

PARENTS
10. NAME OF FATHER John Frost
11. BIRTHPLACE OF FATHER (CITY OR TOWN) London
(STATE OR COUNTRY) England.
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Unknown

14. INFORMANT J. M. Frost.
(Address) Raytown Mo.

15. FILED 10-3, 1928 Dr. W. W. Hobbs
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 4- 1928

17. I HEREBY CERTIFY, That I attended deceased from 8-28-, 1925 to , 19 that I last saw h alive on , 19 , and that death occurred, on the date stated above, at 12 10 P M

THE CAUSE OF DEATH* WAS AS FOLLOWS: Chronic Myocarditis acute Bronchitis
131
93
100
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY) Chronic Interstitial Nephritis (duration) 6 yrs. 0 mos. 0 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical Signs
(Signed) W. W. Hobbs M.D
9-5, 1928 (Address) Raytown 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 Flannery Cemetery
DATE OF BURIAL Sept 5 1928
20. UNDERTAKER W. L. Schick & Son
ADDRESS Lees Summit

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1928
87
41