

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

Do not use this space.

5860

1. PLACE OF DEATH
 County Clay Registration District No. 207 File No. _____
 Township Liberty Primary Registration District No. 5780 Registered No. 17
 City _____ St. _____ Ward _____

2. FULL NAME George W. Frazier
 (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 Male 4. COLOR OR RACE wh. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 16-1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
67 11 12

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

9. BIRTHPLACE (CITY OR TOWN) Clay Co. Mo
 (STATE OR COUNTRY)

10. NAME OF FATHER Henry Frazier

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

12. MAIDEN NAME OF MOTHER Elizabeth Walker

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

14. INFORMANT John Frazier
 (Address) Liberty, Mo

15. FILED 3/19/29 W. H. Godson
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 28 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 17 1929, to Feb 20 1929 that I last saw him alive on Feb 25 1929 and that death occurred, on the date stated above, at 6:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy
and Cerebral Hemorrhage
 (duration) yrs. mos. 11 ds.

CONTRIBUTORY (SECONDARY) 14/10/1
 (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? no
 WHAT TEST CONFIRMED DIAGNOSIS? none
 (Signed) W. H. Godson, M. D.
 (Address) Liberty Mo

*State the DISEASE CAUSING DEATH, or if 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 Providence, Liberty Mo DATE OF BURIAL 3/27 1929

20. UNDERTAKER Church - Archer ADDRESS Liberty Mo

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.

1929

10

2

