

Cause of death 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.

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

Do not use this space.
26360

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Law Primary Registration District No. _____
 City Kansas City (No. 4949) Rockhill Road File No. 3268
 Registered No. _____
 St. 6th Ward _____

2. FULL NAME

Moxie S. Frischer
 (a) Residence, No. 5700 Wyadotte St. 8th Ward. _____
 (Usual place of abode) _____
 Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Ruth Frischer</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Aug. 10, 1891</u>				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
<u>41</u>			<u>16</u>	
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Chemist</u>			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>H</u>			
	10. Date deceased last worked at this occupation (month and year) _____			
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>New York</u>		11. Total time (years) spent in this occupation _____		
MOTHER	13. NAME <u>Goodman Frischer</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>			
	15. MAIDEN NAME <u>Ma Munger</u>			
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>				
17. INFORMANT <u>Dr. Julius Frischer</u> (ADDRESS) <u>63</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Glenn Hill Cemetery Aug 28 1932</u>				
19. UNDERTAKER <u>Carroll Davidson</u> (ADDRESS) <u>302 45th St.</u>				
20. FILED <u>8/27</u> 19 <u>32</u> <u>M. M. Boye</u> Regist.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 26, 1932

22. I HEREBY CERTIFY, That I attended deceased from June 12th, 1932 to Aug 26, 1932
 I last saw him alive on Aug 26, 1932. Death is said to have occurred on the date stated above, at 6:30 P.M.
 The principal cause of death and related causes of importance were as follows:
Abdominal atherosclerosis (Date of onset June 11)
Cerebral 12/13
12/1 1893
12-4 about
 Other contributory causes of importance:
Secondary liver atherosclerosis July 26
1
1 June 11
 Name of operation removal of atherosclerosis Date August 28
 What test confirmed diagnosis? autopsy Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased no
 If so, specify _____
 (Signed) Dr. J. W. Munger M. D.
 (Address) 1314 Professional Bldg.

