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.

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

Do not use this space.

JUN 12 1937

1. PLACE OF DEATH
County Buchanan — Registration District No. ..... — File No. 19486
Township ..... — Primary Registration District No. ..... — Registered No. 577
City St Joseph (No. ..... St. ..... Ward)

2. FULL NAME Frazell Thompson
(a) Residence, No. ..... St., ... Ward. Kansas City Mo
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 6 yrs. 0 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Unknown
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Unknown
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Unknown
7. AGE: about 42 — YEARS — MONTHS — DAYS — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: nil
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown

FATHER
13. NAME: Unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown

MOTHER
15. MAIDEN NAME: Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown

17. INFORMANT (ADDRESS): Records State Hospital St Joseph Mo
18. BURIAL, CREMATION, OR REMOVAL
PLACE Lexington Mo DATE 5/17 1937
19. UNDERTAKER (ADDRESS): Adrain T. Groves Lexington Mo
20. FILED MAY 17 1937 19 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/16 1937

22. I HEREBY CERTIFY, That I attended deceased from 5/14 1931, to 5/16 1937
I last saw her alive on 5/15 1937. Death is said to have occurred on the date stated above, at 12 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Pulmonary Tuberculosis	4/15/36
Other contributory causes of importance:	
Dementia Praecox	5/14/31

Name of operation ..... Date of .....
What test confirmed diagnosis? Clinical Was there an autopsy? No

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 Clifton Smith, M. D.
(Address) State Hospital St Joseph Mo