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.

22-000

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

Do not use this space. 33082

OCT 14 1937

791

1. PLACE OF DEATH

County ..... Registration District No. 1003 File No. 9136

Township ..... Primary Registration District No. ..... Registered No. .....

City ..... (No. Homer G Phillips Hosp. St. ..... Ward)

2. FULL NAME Frazier

(a) Residence, No. 319 S. Garrison, 18 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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: Undet.

4. COLOR OR RACE: Negro

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-13-37

7. AGE: 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.

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) St. Louis Missouri

FATHER

13. NAME Robert Frazier

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss.

MOTHER

15. MAIDEN NAME Mollie Johnson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss.

17. INFORMANT (ADDRESS) Esther Mary Sherard 2601 N. Whittier

18. BURIAL, CREMATION, OR REMOVAL PLACE City Cemetery DATE 9/30/37 19

19. UNDERTAKER (ADDRESS) David Jan Fossan City Hosp #1

20. FILED SEP 29 1937 19 J H Bredeck Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-13-37, 19

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 12:20 m. A M

The principal cause of death and related causes of importance were as follows:

	Date of onset
Unknown (Stillborn Prematurity)	

Other contributory causes of importance:

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? .....

If so, specify .....

(Signed) Thomas C. McFall, M. D.

(Address) 2601 N. Whittier