

9599 DEC 22 1938

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

40135
Do not use this space.

1. PLACE OF DEATH

(a) County Randolph Registration District No. 135
(b) Township Wesberry Primary Registration District No. 3034 Registered No. 214
(c) City Wesberry (d) Street No. 1413 Wright Ave. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

MARGARET CAROLINE FRISTOE
(a) Residence, No. 1413 Wright Ave. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX fr 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John Fristoe
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 14 - 1860
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 78 7 16
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. hardware
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) Pa.

FATHER 13. NAME Henry Hoop

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

MOTHER 15. MAIDEN NAME Susanne Martin

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

17. INFORMANT (ADDRESS) Wm. John Cleeton
Wesberry, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Grand Prairie Cemetery, near Canton, Mo. DATE Dec 7 - 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. J. Fisher
Wesberry, Mo.

20. FILED Dec 1, 1938 Ethel Cleeton
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) NOV 30 - 1938

22. I HEREBY CERTIFY, That I attended deceased from Sept. 9 / 38 to Nov. 30 / 38
I last saw him alive on Nov. 30 - 1938 Death is said to have occurred on the date stated above, at 10:15 P.M.
The principal cause of death and related causes of importance were as follows:

Congestive Heart Failure Date of onset Smith
arterial hypertension months

Name of operation none Date of no
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? no - Date of injury no
Where did injury occur? no
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury no
Nature of injury no

24. Was disease or injury in any way related to occupation of deceased?
If so, specify no
(Signed) W. J. Fisher M. D.
Wesberry, Mo. (Address)

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.

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

1 X16603

2000

RECEIVED

District Health Officer No. 10

District File Number 10-38-763

Date Filed 12-13-38

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by ^{the undersigned} me, or by _____

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed Albert K. McLean

Licensed Embalmer No. 1849

P. O. Address substantia no.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

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

ALL INFORMATION HEREON MUST BE WRITTEN IN INK
Do not use this space.

File No. 40135-
Registered No. 214

1. PLACE OF DEATH
County Randolph Registration District No. 735-
Township _____ Primary Registration District No. 3034
City Moberly (No. _____, _____, _____) St. _____ (Ward _____)

2. FULL NAME Margaret Caroline Fristoe
(a) Residence, No. _____, _____ St., _____ Ward. (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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wid

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
78 7 _____

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) _____

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

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

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL
PLACE _____ DATE _____, 19____

19. UNDERTAKER (ADDRESS) _____

20. FILED _____, 19____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 30 1938

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 _____ m.
The principal cause of death and related causes of importance were as follows:
congestive Heart failure
myocarditis, chronic
A2C
Other contributory causes of importance:
arterial Hypertension

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

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) L. E. Huper, M. D.
(Address) Moberly Mo

MENTAL

Registrar.

