

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.

AUG 16 1939

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

25358
Do not use this space.

1. PLACE OF DEATH
 (a) County Chariton Registration District No. 172
 (b) Township North Creek Primary Registration District No. 3239
 (c) City _____ (d) Street No. _____ Registered No. 7
 (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.
 (If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME 600 Nole & Fry
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Marghadan Fry
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 6 - 1860
 7. AGE YEARS 69 MONTHS 4 DAYS 16 If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as 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) Adair County
 FATHER 13. NAME Frank Fry
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) York, Va.
 MOTHER 15. MAIDEN NAME Rachel E. Minick
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Putnam Co
 17. INFORMANT (ADDRESS) Candorita Cox
 18. BURIAL, CREMATION, OR REMOVAL PLACE St. Leonard DATE July 16 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) S. L. Farland
Mendenhall
 20. FILED July 18 1939 W. D. West Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 16 1939
 22. I HEREBY CERTIFY That I attended deceased from July 16 1939 to July 16 1939
 Last saw him alive on June 1st 1939 Death is said to have occurred on the date stated above, at 1:30 p.m.
 The principal cause of death and related causes of importance were as follows:
Carcinoma of
Distal Esophagus High Node
Left Superior Maxillary
Base.
 Date of onset Dec 1938
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ 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) W. D. West, M. D.
 (Address) Mendenhall

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 9/14/39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....
J. S. Lipard

Licensed Embalmer No. *3970*

P. O. Address.....
Menasha, Wis.

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.