

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.

FILED MAY 2 1940
Registration District No. 297

Primary Registration District No. 3016

Registrar's No. 36

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Washington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Francis Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Columbus Virgil Fryer 660

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced. Widowed

6. (b) Name of husband or wife Ester Fryer 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 15, 1892
(Month) (Day) (Year)

8. AGE: Years 47 Months 8 Days 16 If less than one day _____ hr. _____ min.

9. Birthplace Stanton, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer
Const.

11. Industry or business _____

12. Name Jesse Fryer

13. Birthplace Stanton, Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Mary Jane Headrick

15. Birthplace Stanton, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Ben Wisble
(b) Address St. Clair, Mo.

17. (a) Burial (b) Date thereof 4/3/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Stanton, Mo.

18. (a) Signature of funeral director Casby
(b) Address St. Clair, Mo.

19. (a) April 2, 1940 (b) _____
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin
(c) City or town Pacific
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 31
year 1940 hour 6 minute P M.

21. I hereby certify that I attended the deceased from March 30, 1940 to March 31, 1940
that I last saw him alive on March 31, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia, plural bases
Due to: Pneumonia

Other conditions: none
(Include pregnancy within 3 months of death)

Major findings: ft plural cavity filled with pus
Of operations: _____
Of autopsy: none

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 270
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Joseph J. Mays (M. D. or other) J.M.D.
Address 311 W 4th, Washington, Mo Date signed 4-2-40

110a

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 *H. M. Leroy*
Licensed Embalmer No. *3601*
P. O. Address *S. Chin...*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14820

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 297

Primary Registration District No. 3014

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Washington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay! In hospital or institution..... (Specify whether
In this community..... (Specify whether
years, months, days)

3. (a) PRINT FULL NAME Columbus Virgil Fryer

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day..... min.
47 8 12

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b)..... (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 31
year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia, Sobar
Empyema,

Due to.....
Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Right plural cavity filled with Pus
Of autopsy.....

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work..... (Specify type of place) Means of injury.....

23. Signature Frank J. Mays (M.D. or other)
Address Washington Date signed.....

SUPPLEMENTAL

S-14820