

No. 2
11-10-39
5-17-39
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U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24117
Registrar's No. 2727

Registration District No. 399 Primary Registration District No. 1002

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: K.C. General Hospital
(d) Length of stay: In hospital or institution 1 Mo. & 1 day
In this community 58 Yrs.

3. (a) PRINT FULL NAME Bertha FRAZIER
3. (b) If veteran, name war None 3. (c) Social Security No. no

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Wilton D. Frazier 6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased March 11th, 1882

8. AGE: Years 58 Months 3 Days 24 If less than one day hr. min.

9. Birthplace Kansas City Missouri

10. Usual occupation At Home

11. Industry or business
12. Name Charles A. Bickell
13. Birthplace Canada
14. Maiden name Margaret McGraw
15. Birthplace Tenn.

16. (a) Informant Wilton D. Frazier
(b) Address 3817 East 18th Street.

17. (a) Burial (b) Date thereof 7/15/40
(c) Place: burial or cremation: Elmwood Cemetery

18. (a) Signature of funeral director McIlroy McGilley
(b) Address K. C. Mo.

19. (a) July 8, 1940 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(d) Street No. 3817 East 18th St.
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 5th
year 1940 hour 4 minut 33 P M.

21. I hereby certify that I attended the deceased from June 4th, 1940, 19____, to July 5th, 1940;
that I last saw her alive on July 5th, 1940, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Post operative coronary occlusion
operated 7-1-40 cholecystectomy

Due to _____
Due to _____

Other conditions Acute pulmonary edema and congestion; term. bronchopneumonia

Major findings: _____
Of operations _____
Of autopsy See above

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature Quincy P. Thow (M. D. or other)
Address Med. Dir. K. C. Gen. Hosp. K. C. Mo. signed

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

9412

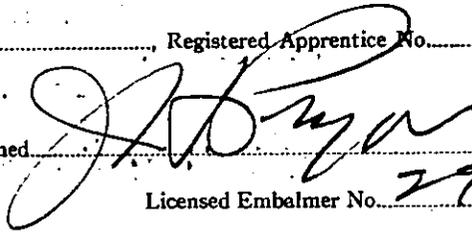
STATEMENT BY LICENSED EMBALMER

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.....



Licensed Embalmer No. 2999

P. O. Address.....

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.

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BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 2727-

1. PLACE OF DEATH

(a) County Jackson
(b) City or town K.C.
(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 _____
years, months or days)

3. (a) PRINT FULL NAME

Bertha Frazer

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

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

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

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

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

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 7/8/40 (b) M. M. Crowe
(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.

20. DATE OF DEATH: Month July day 5 - 40
year _____ 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
Cholelithiasis
Cholecystectomy for cholecystitis

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 127

Major findings:
Of operations _____
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)
(e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

S-24117