No. 2
11-10-39
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
SEP 5 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27562
3195

Registration District No. 399 Primary Registration District No. 1002 Registrar's No.

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
K.C.General Hospital No.1 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 Hrs. (Specify whether
In this community Non-Resident
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State 0 Missouri (b) County Caldwell

(c) City or town Breckenridge, Mo.
(If outside city or town limits write "RURAL")

(d) Street No. ---- Rural
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME RUSSELL FRYER 660

3. (b) If veteran, name war NO

3. (c) Social Security No. No

4. Sex Male

5. Color or race Wh

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec. 22, 1904
(Month) (Day) (Year)

8. AGE: Years 35 Months 7 Days 19 If less than one day hr. min.

9. Birthplace Breckenridge, Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Ollie Fryer
13. Birthplace Breckenridge, Mo. 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Cora Burry
15. Birthplace Ludlow, Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Ollie Fryer
(b) Address Breckenridge, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-12-40 (Month) (Day) (Year)
(c) Place: burial or cremation Monroe Center, Mo.

18. (a) Signature of funeral director Carroll Davidson
(b) Address 5024 Troost

19. (a) Aug. 12, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 11th
year 1940 hour 10 minute 20 A M.

21. I hereby certify that I attended the deceased from 8-11-40, 19__, to 8-11-40, 19__;
that I last saw him alive on 8-11-40, 19__;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Subdural abscess (brain) left	
Due to 78	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy See above	

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?
(Specify type of place)
While at work? (e) Means of injury 1

23. Signature Drury R. Thorn (M. D. or other)
Address Med. Dir. K.C. Gen. Hosp. K.C. Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 E. P. Casey

Licensed Embalmer No. 1972

P. O. Address 9024 Frost

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

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