

10-39
7-39
X21492

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

Registration District No. 701 Primary Registration District No. 5930 State File No. _____ Registrar's No. 36

1. PLACE OF DEATH:
(a) County Polk Marion Burns
(b) City or town Bolivar Missouri
(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 _____ years, months or days) 610

3. (a) PRINT FULL NAME Louis Ignatius Frohoff
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race W 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 February 2 1907
(Month) (Day) (Year)

8. AGE: Years 33 Months 7 Days 0 If less than one day _____ hr. _____ min.

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

10. Usual occupation Grocer Clerk

11. Industry or business _____

MOTHER { 12. Name Bernard Frohoff
FATHER { 13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Magdeline Harris
15. Birthplace Alsace Loraine France
(City, town, or county) (State or foreign country)

16. (a) Informant Clara Riggins
(b) Address Kansas City, Mo.

17. (a) Removal (b) Date thereof Sept 2 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Kansas City, Kans

18. (a) Signature of funeral director White - Burial
(b) Address Bolivar, Missouri

19. (a) 9/2/ (b) J. J. Robert
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Kansas (b) County Wyandotte
(c) City or town Kansas City, Kansas
(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. Foreign years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 2
year 1940 hour 10 minute 45 a. M.

21. I hereby certify that attended the deceased from 7:45 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 apoplexy Duration _____
Due to _____
Due to _____

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

Major findings: _____
Of operations _____
Of autopsy _____

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? _____

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

23. Signature J. P. Hutchinson Coroner 5
Address Bolivar Date signed Sept 2

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 Frank Grable Jr.

Licensed Embalmer No. 4140

P. O. Address Baliviar, Mo.

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.