

S. No. 2
M-5-42
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED FEB 8 1943

Registrar's No. 176

Registration District No. 316

Primary Registration District No. 6075

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

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Farmington RURAL St. Francois
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Mo. State Hospital No. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 month 6 das
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott

(c) City or town Commerce
(If outside city or town limits, write "RURAL")

(d) Street No. Unk.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT GEORGIA RUTH FRAZER
FULL NAME

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 3rd
year 1943 hour 3 minute 0 P. M.

3. (b) If veteran, name war No

3. (c) Social Security No. None

21. I hereby certify that I attended the deceased from Nov. 28th 1942 to Jan. 3 1943
that I last saw her alive on Jan. 3 1943
and that death occurred on the date and hour stated above.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Dr. T. F. Frazer

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

7. Birth date of deceased Unk. Unk. 1862
(Month) (Day) (Year)

Immediate cause of death Senile Dementia Duration 12 mo

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

81 hr. min.

Due to 162d

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

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation Housewife

PHYSICIAN

11. Industry or business

Major findings: Of operations

Of autopsy No autopsy.

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name William McPheeters

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

14. Maiden name Ruth Ross

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

16. (a) Informant Records State Hospital No. 4

(b) Address Farmington, Mo.

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

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof 1-4-43
(Month) (Day) (Year)

(c) Place: burial or cremation Commerce Cem., Commerce, Mo.

(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.....

18. (a) Signature of funeral director Brinkoff - Howell

(b) Address Cape Girardeau, Mo

23. Signature Alfred H. Schwab, M.D. (M. D. or other)

State Mo. Registrar's signature State Hosp Farmington, Mo. Date signed 3-42

19. (a) Jan. 13 1943 (b) Tyndie Buhmester
(Date received local registrar) (Registrar's signature)

1196

RECEIVED

Health Officer No. 4
District File Number 243-1684
Date Filed 2-5-43

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 *John E. Powell*

Licensed Embalmer No. 3390

P. O. Address *Cape Girardeau, 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, fact should be so stated above.