S. No. 2
M—5-42
17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10530

FILED MAR 29 1943

Registration District No. 29 1943

Primary Registration District No. 2001

Registrar's No. 153

1. PLACE OF DEATH:

(a) County Jasper

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

(c) Name of hospital or institution:
St. John's Hosp. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 week (Specify whether
In this community 35 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 49

(a) State Missouri (b) County Jasper 2

(c) City or town Joplin 5
(If outside city or town limits, write "RURAL")

(d) Street No. 207 N. Cox
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Joe Frye

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 Married

6. (b) Name of husband or wife Laura Frye

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased February (Month) 12 (Day) 1879 (Year)

8. AGE: Years 64 Months ** Days 29 If less than one day ___ hr. ___ min.

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

10. Usual occupation None

11. Industry or business

FATHER
12. Name Daniel Frye
13. Birthplace (City, town, or county) Indiana (State or foreign country)

MOTHER
14. Maiden name Mary Lawson
15. Birthplace (City, town, or county) Indiana (State or foreign country)

16. (a) Informant Mrs Lois Dame
(b) Address 103 S. Mineral, Joplin, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/43 (Month) (Day) (Year)
(c) Place: burial or cremation Ozark Memorial Pk.

18. (a) Signature of funeral director Hurlbut Und. Co.
(b) Address Joplin Mo.

19. (a) 3-12-43 (Date received local registrar) (b) Gertrude Sudhoeller (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10
year 1943 hour 10 minute 35 P.M.

21. I hereby certify that I attended the deceased from Jan. 31, 1943, to Mar. 10, 1943
that I last saw h___ alive on ___, 19___;
and that death occurred on the date and hour stated above.

Immediate cause of death Hyp. Stilic Pneumonia

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

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?
(Specify type of place)

While at work? (e) Means of injury 0

23. Signature C. C. Coates (M. D. or other)
Address 306 Grass St Joplin Date signed 3-12-43

1204

(Licensed Embalmer's Statement on Reverse Side)

43-3-242

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.....

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, fact should be so stated above.

V. S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10530

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 153

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

1. PLACE OF DEATH:

(a) County: Jasper

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

(c) Name of hospital or institution: St John's Hosp
(If not in hospital or institution, write street number or location)

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

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) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME: Joel Fryl

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: M

6. (b) Name of husband or wife .....

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

7. Birth date of deceased: Feb (Month) 12 (Day) 1879 (Year)

8. AGE: Years 64 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 .....

MOTHER FATHER

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day ..... year 1943 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: Hypostatic Pneumonia

Due to: Lobar Pneumonia

Due to .....

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

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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature: H. E. Coats (M. D. or other)

Address: Joplin Mo Date signed: 4-30-43

SUPPLEMENTARY

108