

No. 2  
-9-4-41  
-5-17-39  
X298

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **14144**

DECEASED **MAY 8 1943**

Registration District No. **98**

Primary Registration District No. **5368**

Registrar's No. **50**

1. PLACE OF DEATH: **Davies**

(a) County: **Davies**

(b) City or town: **Rural Salem Twp**  
(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: **most of life**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State: **Mo** (b) County: **Davies**

(c) City or town: **Pattonsburg R.P.**  
(If outside city or town limits, write "RURAL")

(d) Street No.: **Salem Twp**  
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country: **/**

3. (a) PRINT FULL NAME: **William Frazier**

3. (b) If veteran, name war: **/**

3. (c) Social Security No.: **/**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **13**  
year **1943** hour **2** minute **A.M.**

4. Sex: **Male**

5. Color or race: **white**

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

6. (b) Name of husband or wife: **Alice Frazier**

6. (c) Age of husband or wife if alive: **80** years

7. Birth date of deceased: **Feb 25 1861**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **April 10 1943** to **April 13 1943**  
that I last saw him alive on **April 13/43**  
and that death occurred on the date and hour stated above.

8. AGE: Years **81** Months **3** Days **18**  
If less than one day: **/** hr. **/** min.

Immediate cause of death: **Cerebral Hemorrhage**  
Duration: **5 days**

Due to: **/**

Due to: **/**

9. Birthplace: **Iowa**  
(City, town, or county) (State or foreign country)

Other conditions: **/**  
(Include pregnancy within 3 months of death)

10. Usual occupation: **Farming**

11. Industry or business: **Farming**

12. Name: **David Frazier**

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

14. Maiden name: **not known**

15. Birthplace: **/**  
(City, town, or county) (State or foreign country)

Major findings: **/**  
Of operations: **/**

Of autopsy: **/**

PHYSICIAN: **/**  
Underline the cause to which death should be charged statistically.

16. (a) Informant: **Willie Frazier**

(b) Address: **Pattonsburg Mo**

17. (a) **Burial** (b) Date thereof: **4 14 43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **Bethel Cemetery**

18. (a) Signature of funeral director: **S. O. Dickerson**

(b) Address: **Pattonsburg Mo**

19. (a) **4-15-43** (b) **S. O. Dickerson**  
(Date received local registrar) (Registrar's signature)

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: **John D. Graham** (M. D. or other): **/**

Address: **Pattonsburg Mo** Date signed: **4/15/43**

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

25071088

(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..... *G. S. Granger*

Licensed Embalmer No. *2857*

P. O. Address *Pattersonburg 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 98

Primary Registration District No. 0-368

Registrar's No. 0-0

1. PLACE OF DEATH:

(a) County (Davis)  
(b) City or town Rural Salem Twp  
(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 \_\_\_\_\_ (Specify whether)  
years, months or days

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 William Frazier

3. (b) If veteran, \_\_\_\_\_ 3. Social Security No. \_\_\_\_\_  
name war \_\_\_\_\_

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 Dec 25  
(Month) (Day) (Year)

8. AGE: Years 91 Months 3 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry of 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) 5-10-43 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

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? \_\_\_\_\_  
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

MOTHER FATHER

SUPPLEMENTARY 3

S-74244