

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

24739  
Do not use this space.

**FILED AUG 7 1943**

1. PLACE OF DEATH  
 (a) County Clinton Registration District No. 75  
 (b) Township Shoal Primary Registration District No. 3015 Registered No. 50  
 (c) City Cameron (d) Street No. 1 St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Fred Fry  
 (a) Residence, No. City St.  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs Gerturde  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 13th. 1878  
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
64 10 25

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Salesman  
 9. Industry or business in which work was done, as saw mill, bank, etc. on road  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Logan (STATE OR COUNTRY) Iowa

FATHER  
 13. NAME Ammon Fry  
 14. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) Ky

MOTHER  
 15. MAIDEN NAME Mary Ann McKenzie  
 16. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) England

17. INFORMANT Frank A Fry (ADDRESS) Port Huron, Mich

18. BURIAL, CREMATION, OR REMOVAL PLACE Logan Iowa DATE July 9, 1943

19. FUNERAL DIRECTOR (NAME) W. O. Morrow (ADDRESS) Cameron, Mo.

20. FILED 7/9/43 19 Mrs. Kathleen Harris Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 8<sup>th</sup> 1943  
 22. HEREBY CERTIFY That I attended deceased from June 18, 1943 to July 8, 1943  
 I last saw him alive on July 7, 1943 Death is said to have occurred on the date stated above, at 12:45 AM  
 The principal cause of death and related causes of importance were as follows:

Angina Pectoris Date of onset 20 days  
 Other contributory causes of importance: Acute Nephritis 20 days

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? NO  
 If so, specify \_\_\_\_\_  
 (Signed) W. O. Gilliland, M. D.  
 (Address) 20 Cameron, Mo.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**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..... *C. M. Moore*

Licensed Embalmer No. *1180*

P. O. Address *Cameron Tc*

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

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

Registration District No. 75 Primary Registration District No. 3015 Registrar's No. 50

1. PLACE OF DEATH:  
(a) County Clinton  
(b) City or town Cameron  
(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)

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

20. DATE OF DEATH: Month July day \_\_\_\_\_ year 1943 minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: Aug 13 1917  
(Month) (Day) (Year)  
8. AGE: Years 64 Months 10 Days 12 If less than one day \_\_\_\_\_ min.

Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions: acute nephritis  
(Include pregnancy within 3 months of death)  
Cause not known  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy 94h

9. Birthplace Iowa (City, town, or county) (State or foreign country)  
10. Usual occupation \_\_\_\_\_  
11. Industry or 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)

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? \_\_\_\_\_

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) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature A. O. [unclear] (M. D. or other)  
Address Cameron, Mo Date signed 8/2/43

WHILE PLAINLY VISIBLE, USING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

S-24739