

BUREAU OF THE CENSUS
FILED APR 13 1944

Registration District No. 4 D

Primary Registration District No. 5122

Registrar's No.

1. PLACE OF DEATH:

(a) County Boone
 (b) City or town Brown Station Rocky Ford Twp
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Brown Station
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 78 Years
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME ROBERT BLEDSOE FRAZER

3. (b) If veteran, name war None
 3. (c) Social Security No. None

4. Sex Male
 5. Color or race White
 6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife Fannie Alberta Frazer
 6. (c) Age of husband or wife if alive 11 - 15 years

7. Birth date of deceased 11 - 15 - 1865
 (Month) (Day) (Year)

8. AGE: Years 78 Months 4 Days 23
 If less than one day hr. min.

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

10. Usual occupation Retired

11. Industry or business

12. Name Robert Frazer
 13. Birthplace Kentucky
 (City, town, or county) (State or foreign country)
 14. Maiden name Narcissus Case
 15. Birthplace Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. R. L. Davis
 (b) Address Brown Station, Mo.

17. (a) Burial (b) Date thereof 4-11-44
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oakland Cemetery

18. (a) Signature of funeral director Parson Funeral Service
 (b) Address Columbia, Mo.

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone
 (c) City or town Brown Station
 (If outside city or town limits, write "RURAL")
 (d) Street No. (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 8
 year 1944 hour 3:45 minute A. M.

21. I hereby certify that I attended the deceased from 11-20-
1943 to 4-8-
1944
 that I last saw him alive on 4-7-
1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
 Duration few days

Due to Old age & a brain
rip 11-17-43

Due to None

Other conditions None
 (Include pregnancy within 3 months of death)

Major findings: None
 Of operations None
 Of autopsy None

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) No
 (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? No (Specify type of place)
 (e) Means of injury

23. Signature Dr. J. L. Davis (M. D. or other)
 Address Columbia, Mo. Date signed 4-10-44

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.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed

Licensed Embalmer No. *413*

P. O. Address *Columbia*

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

If this body is not embalmed, fact should be so stated above.

Registration District No. 40

Primary Registration District No. 5122

1. PLACE OF DEATH:

(a) County Boone Rocky
(b) City or town Brown Station Farmington
(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

3. (a) PRINT FULL NAME Robert Bledsoe Troyer
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color of race w 6. (a) Single, widowed, married, divorced w

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

7. Birth date of deceased Nov 15 (Month) (Day) (Year)

8. AGE: Years 78 Months 4 Days 15 (Unless than one day) _____ min.

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

MOTHER FATHER { 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)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) Apr 15, 1944 (b) Mrs. Ralph Bryan
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April year 1944 hour _____ minute _____ M.

21. I hereby certify that I watched the deceased from _____ 19____; that I last saw him _____ alive on _____ 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 _____

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) _____

Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

USE PENCILING BACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

10385