

FILED MAY 25 1944  
179

Registration District No. 179

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
647 W. 39th. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 42 years (Specify whether years, months or days)  
In this community 42 years

3. (a) PRINT FULL NAME Luther Eucl Frazier

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

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

6. (b) Name of husband or wife Mrs. Rose Frazier 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased: July 27 1870  
(Month) (Day) (Year)

8. AGE: Years 73 Months 9 Days 17 If less than one day 0 hr. min.

9. Birthplace Ray Co. Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Foreman steamfitters Ret.

11. Industry or business Soap Company

12. Name John Frazier

13. Birthplace Ray Co. Mo. (City, town, or county) (State or foreign country)

14. Maiden name Laura Frazier

15. Birthplace Ray Co. Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Rose Frazier

(b) Address 647 W. 39th

17. (a) Burial (b) Date thereof May 16 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cem

18. (a) Signature of funeral director State Funeral Home

(b) Address Kansas City Kansas

19. (a) 5-16-44 (b) N. C. Brown  
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 647 W. 39th.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14 year 1944 hour --- minute --- M.

21. I hereby certify that I attended the deceased from June 1943 to May 14 1944  
that I last saw him alive on May 14 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis 6M0  
Cerebral hemorrhage, 6M0

Due to 930

Due to Arteriosclerosis

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

Major findings: Of operations no

Of autopsy no

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. B. Carls (or other)

Address 4000 Raltimore Date signed 5-15-44

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

MOTHER FATHER

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

Dr. Carebolt  
4000 Baltimore  
Va 5114

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..... *W. L. Ward*

Licensed Embalmer No. .... 3991

P. O. Address..... 309 E 67<sup>th</sup> St  
S.E.M.C.

**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.