

Registration District No. 236

Primary Registration District No. 5819

Registrar's No. 23

1. PLACE OF DEATH:

(a) County MORGAN OSAGE TWP.
 (b) City or town RURAL - GRAVOIS MILLS
 (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 6 years
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County MORGAN
 (c) City or town RURAL - OSAGE
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2 MILES S.E. OF GRAVOIS MILLS
 (If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME SARAH-LOUISA-FRAZIER

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 2

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

7. Birth date of deceased JAN 12 1854
 (Month) (Day) (Year)

8. AGE: Years 90 Months 3 Days 24 If less than one day _____ hr. _____ min.

9. Birthplace MILAN - MISSOURI
 (City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business HOMIE

MOTHER FATHER { 12. Name WILLIAM JACKSON

13. Birthplace VIRGINIA
 (City, town, or county) (State or foreign country)

14. Maiden name BALDRICE

15. Birthplace VIRGINIA
 (City, town, or county) (State or foreign country)

16. (a) Informant Roland B. Frazier

(b) Address Hickman Mills Mo

17. (a) Removal (b) Date thereof 5-9-44
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FOREST-HILLS K.C. MO

18. (a) Signature of funeral director W. F. Kull
 (b) Address Versailles Mo

19. (a) 5-9-1944 (b) Ray Berbestrean
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 6
 year 1944 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from June 1st
 1944, to May 6th 1944

that I last saw her alive on May 5th 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Organic heart disease

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 W. S. Gunn (M. D. or other)

Address Versailles Mo Date signed 5-9-44

Duration

Several years

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

Health Officer No. 74

City Number 5-44-727

County 6-7-44

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed A. F. Kimmel

Licensed Embalmer No. 1596

P. O. Address Versailles, 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.

Registration District No. 236

Primary Registration District No. 5-819

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

1. PLACE OF DEATH:

(a) County Morgan
(b) City or town Brenton
(If outside city or town limits, write "RURAL" or 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)

3. (a) PRINT FULL NAME Isabel L. Freger

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced WIDOWED

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

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

8. AGE: Years 90 Months 3 Days no. (Unless than one day) min.

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

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) Roy Berbestresser (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 Jan year 1944 hour..... minute..... M.

21. I hereby certify that I attended 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.....

Duration

Due to.....

Due to.....

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

Major findings: Of operations.....

Of autopsy.....

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.....

SUPPLEMENTARY

OCT 27 1944

18720