

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33137

State File No. _____

4235

Registrar's No. _____

FILED NOV 13 1944
1279

Registration District No. _____

Primary Registration District No. 1002

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

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:
1409 Charlotte
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ 40 years _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Mrs Mary A. Frasch

3. (b) If veteran, name war _____ no

3. (c) Social Security No. _____ no

4. Sex Fe | 5. Color or race wh | 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Wm Geo Frasch (Deceased) | 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased dont know
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day
Think 71 hr. _____ min.

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

10. Usual occupation Home

MOTHER FATHER

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Carl F. Frasch

(b) Address 1409 Charlotte

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 23rd 1944
(Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

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

(b) Address 1800 Linwood

19. (a) Oct 23 1944 (Date received local Registrar) J E Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 1409 Charlotte
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____ no _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 20th
year 1944 hour 10 minute 30 PM.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the _____ day and hour stated above.

Immediate cause of death Coronary Arteriosclerosis

Due to _____

Due to _____ 94a

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

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____

Of autopsy Inspection History

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)

23. Signature A. E. Usher (M. D. or other) MD
2811 McCoy Date signed 10/24/44

Address _____

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 Chas. E. Wilks

Licensed Embalmer No 2644

P. O. Address 1800 Linwood

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.