

FILED OCT 23 1945 STANDARD CERTIFICATE OF DEATH

State File No. **33454**

Registration District No. **59**

Primary Registration District No. **4093**

Registrar's No. **14**

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

1. PLACE OF DEATH:

(a) County Cass
(b) City or town East Lynne
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Cass **19**
(c) City or town East Lynne **0**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) **0**
(e) If foreign born, how long in U. S. A.? _____ years. **0**

3. (a) PRINT FULL NAME JAMES I. FRASURE

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

4. Sex M 5. Color or race Wh. 8. (a) Single, widowed, married, divorced divorced

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

7. Birth date of deceased May 12 1859
(Month) (Day) (Year)

8. AGE: Years 86 Months 5 Days 20 If less than one day hr. _____ min. _____

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

10. Usual occupation Carpenter

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 Ken Frasure

(b) Address pleasant Harrowsville Mo.

17. (a) Burial (b) Date thereof 9-4-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pat's Chapel

18. (a) Signature of funeral director G. D. Natzler

(b) Address East Lynne Mo.

19. (a) Oct 8-45 (b) Dama J. Jones
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 2
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Aug 21
1945 to Sep 1 1945
that I last saw him alive on Sep 1 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Lungs Duration _____

Due to _____

Due to _____

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

Major findings: Of operations 53

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 B. M. Griffith (M. D. or other) _____
Address Harrowsville Date signed Sep 31 1945

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 _____

Licensed Embalmer No. 2717

P. O. Address East Lynne, 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, above space should be left blank.