

No. 2
9-4-41
5-17-39
X29484

FILED NOV 8 1945

Registration District No. **72** Primary Registration District No. **5289**

Registrar's No. **90**

1. PLACE OF DEATH:

(a) County **Clay**
(b) City or town **Rural Gallatin**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Home**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **23 yrs** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Clay**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **#5 North Kansas City**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME

Eliza ANN Frost

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

4. Sex **F** 5. Color or race **Wht** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Henry F Frost** 6. (c) Age of husband or wife if alive **74** years
7. Birth date of deceased **Sept 4 1873**
(Month) (Day) (Year)

8. AGE: Years **72** Months **1** Days **15** If less than one day hr. min.

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

10. Usual occupation **H. W.**

11. Industry or business

MOTHER FATHER
12. Name **John Lewis**
13. Birthplace **Ky**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Margaret Whiskerson**
15. Birthplace **Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Mary GREEN**
(b) Address **Rathrip Mo**

17. (a) **Burial** (b) Date thereof **10-22-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Holt Mo**

18. (a) Signature of funeral director **Morton Federal Home**
(b) Address **North Kansas City Mo**

19. (a) **Oct 22 - 1945** (b) (Registrar's signature)
(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **19** year **1945** hour **10** minute **P** M.

21. I hereby certify that I attended the deceased from **About 12 years**, 19 to 19, that I last saw him alive on **Oct 19 75**, 19, and that death occurred on the date and hour stated above.

Immediate cause of death **Sclerosis of Cord with paraplegia for 10 years**
Due to

Due to
Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations **pp. 1**
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 **W. J. Anderson** (M.D. or other)
Address **Liberty Mo** Date signed **Oct 19 45**

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

1411

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 11-6-50

NOV 27 1950

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.....

John Miller

Licensed Embalmer No: 4349

P. O. Address.....

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. 72

Primary Registration District No. 5289

Registrar's No. 90

1. PLACE OF DEATH:
 (a) County Clay
 (b) City or town Rural Clayton Township
(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 _____
years, months or days

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 _____

3. (a) PRINT FULL NAME Eliza Ann Frost
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month _____ Day _____
 year 1940 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____
 to _____, 19____;
 that I last saw him/her on _____, 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

4. Sex F
 5. Color or race W
 6. (a) Single, widowed, married, divorced m
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: Sept (Month) 4 (Day) 1904 (Year)

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

8. AGE: Years 72 Months 1 Days _____
If less 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 _____
 15. Birthplace _____
(City, town, or county) (State or foreign country)

PHYSICIAN _____
 Major findings:
 Of operations _____
 Of autopsy _____
Underline the cause to which death should be charged statistically.

16. (a) Informant _____
 (b) Address _____
 17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____
 18. (a) Signature of funeral director _____
 (b) Address _____

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?
(Specify type of place)
 While at work? _____ (e) Means of injury _____

19. (a) Oct 22 - 1940 (Date received local registrar)
 (b) Paulah Ditcher (Registrar's signature)

23. Signature _____ (M. D. or other)
 Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

33546