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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36858

FILED DEC 12 1945

State File No. _____

Registration District No. _____

Primary Registration District No. 3011

Registrar's No. 36

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Carrollton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Atwood Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 months
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll

(c) City or town Carrollton
(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 CELESTINE FRAZIER

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 1
year 1945 hour 7 minute 15 M.

21. I hereby certify that I attended the deceased from Aug 30th
1945 to 12-1, 1945
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

4. Sex Fe 5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife R. Frazier

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

7. Birth date of deceased Nov 23 1862
(Month) (Day) (Year)

Immediate cause of death hypostatic Pneumonia 1 w.

8. AGE: Years 83 Months 0 Days 8 If less than one day hr. _____ min. _____

Due to Fracture right hip

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

Due to _____

10. Usual occupation at Home

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

MOTHER FATHER

11. Industry or business _____

12. Name Sylvestre Poire

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

14. Maiden name Aimee G. Keefe

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

Major findings: Of operations _____

Of autopsy _____

1945

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Frank Bentley

(b) Address Carrollton Mo.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

17. (a) Burial (Burial, cremation, or removal) _____

(b) Date thereof 12-3-45
(Month) (Day) (Year)

(c) Place: burial or cremation Haley Mo.

(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? _____

18. (a) Signature of funeral director Stanley Hubon

(b) Address Carrollton Mo.

19. (a) 12-2-45 (Date received local registrar)

(b) Mrs. Herbert Colvert (Registrar's signature)

While at work? _____
(Specify type of place)

(c) Means of injury _____

23. Signature William S. Atwood (M. D. or other) _____

Address Carrollton Mo. Date signed 12/1/45

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

142

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 12-12-65

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: Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address: Carrollton, Va

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.