

FILED Aug 17 1946

State File No. \_\_\_\_\_  
Registrar's No. 1649

Registration District No. \_\_\_\_\_ Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Jefferson Barracks  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Veterans Administration Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution Since 6-17-46  
(Specify whether  
In this community 29 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town Mexico  
(If outside city or town limits, write "RURAL")  
(d) Street No. 516 E. Breckenridge  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME FRY, Johnnie

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

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Dorothy Fry 6. (c) Age of husband or wife if alive 28 years  
7. Birth date of deceased July 31 1916  
(Month) (Day) (Year)

8. AGE: Years 30 Months 0 Days 5  
If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation None

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Charley Fry  
13. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Carrie (Unknown)  
(City, town, or county) (State or foreign country)  
15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Clinical Clerk, Vet. Adm. Hosp.

(b) Address Jefferson Barracks, Missouri

17. (a) Removal (b) Date thereof 8-8-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mexico, Mo.  
Gates Funeral Home

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address 4107 Finney - St. Louis, Missouri

19. (a) 8-8-46 (b) L. E. Stillwell  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 6  
year 1946 hour 4:32 minute 5 M.

21. I hereby certify that I attended the deceased from 6-17-46, 19\_\_\_\_, to 8-6-46, 19\_\_\_\_,  
that I last saw him alive on August 6, 1946,  
and that death occurred on the date and hour stated above.

Immediate cause of death PNEUMONIA, SUPPURATIVE, Duration  
LEFT LOWER LOBE UNK

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions BRAIN ABSCESS UNK  
(Include pregnancy within 3 months of death)

Major findings: No Operation PHYSICIAN  
Of operations \_\_\_\_\_

Of autopsy No Autopsy  
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) NO

(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? L. E. Stillwell (Specify type of place) \_\_\_\_\_  
Means of injury \_\_\_\_\_

Signature L. E. STILLWELL, M.D. (M. D. or other) \_\_\_\_\_

Address Vet. Adm. Hosp., Jeff. Brks., MO. Date signed 8-7-46

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

JAN 6 1948

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.....  
Thomas J. Gates..... Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No..... 4259

P.O. Address..... 4107 Finney Ave.

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.