

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21925

FILED JUN 17 1948

Registration District No. 381

Primary Registration District No. 45-15-

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Milau
(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 _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sullivan
(c) City or town Milau 105
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Hilma Margaret Frazier

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife C. B. Frazier 6. (c) Age of husband or wife if alive 44 years
7. Birth date of deceased: 9 (Month) 13 (Day) 1907 (Year)

8. AGE: Years 40 Months 8 Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name hon Mrs Ewen

13. Birthplace Milau (City, town, or county) Sullivan Co - Mo (State or foreign country)

14. Maiden name Maey Ya. Aley

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

16. (a) Informant C. J. Frazier

(b) Address Milau

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-22-48 (Month) (Day) (Year)

(c) Place: burial or cremation Oakwood - Milau

18. (a) Signature of funeral director Schwarz

(b) Address Milau - Mo
19. (a) June 2 - 1948 (Date received local registrar) (b) Mrs. H. B. Harris (Registrar's signature) 220

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 20 year 1948 hour 10 minute 40 a. M.

21. I hereby certify that I attended the deceased from May 20 1948 to May 20 1948 that I last saw her alive on May 20 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma uterus and adjoining organs. 2 1/2 yrs
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

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. Simpson (M. D. or other) 400
Address Milau, Mo. Date signed 5-22-48

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED
District Health Officer No. 10
District File Number 6-48-105
Date Filed JUN 16 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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed..... *Dwight Schaefer*

Licensed Embalmer No. 2667

P. O. Address..... *Milwaukee - Wis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. _____

Registration District No. 381

Primary Registration District No. 4515

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town milan
(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)

3. (a) PRINT FULL NAME

Hilma M Frazier

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

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 _____

7. Birth date of deceased Sept 13 (Month) (Day) (Year)

8. AGE: Years 40 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER { 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 _____
(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATE FROM

20. DATE OF DEATH: Month _____ Year _____ hour _____ minute _____ M.

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

Duration

Due to _____

Due to _____

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

Major findings: Of operations _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

5-21925