

FILED APR 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11615

BIRTH NO. _____		REG. DIST. NO. 42		PRIMARY REG. DIST. NO. 1000		Registrar's No. 438		
1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan				
b. CITY OR TOWN St. Joseph		c. LENGTH OF STAY (in this place) 5 months		c. CITY OR TOWN St. Joseph				
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Methodist Hospital				d. STREET ADDRESS (If rural, give location) 2400 Jackson				
3. NAME OF DECEASED a. (First) Jessie			b. (Middle) Frazier		c. (Last) Worth		4. DATE OF DEATH (Month) (Day) (Year) 4/19/49	
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH 3/5/1869		
9. AGE (in years last birthday) 80		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 1 YEAR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Utica, New York		
12. CITIZEN OF WHAT COUNTRY? US				13a. FATHER'S NAME George Frazier		13b. MOTHER'S MAIDEN NAME Jane Storey		
14. NAME OF HUSBAND OR WIFE Charles Worth				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		
17. INFORMANT'S SIGNATURE OR NAME Mrs. A. R. Byars				ADDRESS St. Joseph, Mo.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chl. Sympathetic Paralysis				INTERVAL BETWEEN ONSET AND DEATH 6 1/2
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from Oct 1942 to 6-19, 1949 that I last saw the deceased alive on 4-18, 1949 and that death occurred at 8:20 A.M., from the causes and on the date stated above.								
23a. SIGNATURE L. H. Jensen M.D.				23b. ADDRESS St. Joseph Mo		23c. DATE SIGNED 4-19-49		
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 4/19/49		24c. NAME OF CEMETERY OR CREMATORY Brookfield		24d. LOCATION (City, town, or county) (State) Mo.		
DATE REC'D BY LOCAL REG. April 21, 1949		REGISTRAR'S SIGNATURE E. B. Jenkins 385		25. FUNERAL DIRECTOR'S SIGNATURE Heaton Bowman Funeral Home		ADDRESS St. Joseph Mo.		

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

AUG 2 1945

DR J. J. ...

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.....

Student Embalmer No.

working under my personal supervision.

Signed James B. Hawkin

Signed
Student Embalmer

Licensed Embalmer No. 4536

P. O. Address 319 S. 10th St. Joseph, 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, fact should be so stated above.