

FILED JUN 18 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19540
Registrar's No. 2420

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

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| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City | |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION General Hospital No. 1 | | d. STREET ADDRESS (If rural, give location) 3217 Cleveland | |

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| 3. NAME OF DECEASED (Type or Print) a. (First) John | b. (Middle) Frye | c. (Last) Frye | 4. DATE OF DEATH (Month) May (Day) 25 (Year) 1949 |
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| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Unknown | 8. DATE OF BIRTH Unknown 1860 | 9. AGE (In years last birthday) 89 | IF UNDER 1 YEAR Months | IF UNDER 11 HRS. Days | Hour | Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during course of working life, even if retired) Pensioner | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Unknown | | 12. CITIZEN OF WHAT COUNTRY? | | |

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| 13a. FATHER'S NAME Unknown | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. Unknown | 17. INFORMANT'S SIGNATURE OR NAME Record Clerk: P.C. Genhage #1 | ADDRESS |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia Senility | INTERVAL BETWEEN ONSET AND DEATH 19 hrs. |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
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| 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) m. | 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 May 24, 1949, to May 25, 1949, that I last saw the deceased alive on May 25, 1949, and that death occurred at 10:52 m., from the causes and on the date stated above.

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| 23a. SIGNATURE Wm. W. Hart (Degree or title) | 23b. ADDRESS Med. Dir. General Hospital No. 1 | 23c. DATE SIGNED |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) Entombed | 24b. DATE 6-3-49 | 24c. NAME OF CEMETERY OR CREMATORY Western Dental Col. | 24d. LOCATION (City, town, or county) (State) Kansas City, Mo. |
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| DATE REC'D BY LOCAL REG. 6-3-49 | REGISTRAR'S SIGNATURE Geraldine Holmes | 25. FUNERAL DIRECTOR'S SIGNATURE B. E. Weichert | ADDRESS K.C., Mo. |
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(Licensed Embalmer's Statement on Reverse Side)

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

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Blaine E. Weichert

Signed.....
Student Embalmer

Licensed Embalmer No. *4075*

P. O. Address *K.C. 8, 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.