

FILED SEP 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26891

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3521

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>	
c. LENGTH OF STAY (in this place) <u>40 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>4310 Mercier</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Luke's Hospital</u>			

3. NAME OF DECEASED a. (First) <u>DONALD</u>		b. (Middle) <u>R.</u>		c. (Last) <u>FRASER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 13 1949</u>		
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5. SEX <u>M</u>		16. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>Oct. 28, 1867</u>		9. AGE (in years) (by birthday) <u>81</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Scotland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
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13a. FATHER'S NAME <u>Unknown</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Lottie L Fraser</u>		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Ralph Connett 4310 Mercier</u>			
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: <u>(b) Carcinoma of colon (recto sigmoid)</u> ANTECEDENT CAUSES: <u>(a) with complete intestinal obstruction</u> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>153X</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years - 4 days</u>	
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19a. DATE OF OPERATION <u>8/11/49</u>		19b. MAJOR FINDINGS OF OPERATION <u>Cecostomy done - distended colon found</u>						20. AUTOPSY? YES <input checked="" 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)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from 8/9, 1949, to 8/13, 1949, that I last saw the deceased alive on 8/13, 1949, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE <u>Edward H. Klein</u> (Degree or title) <u>M.D.</u>			23b. ADDRESS <u>Plaza Med Bldg.</u>			23c. DATE SIGNED <u>8/15/49</u>		
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8/15/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Pk.</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas city Mo.</u>			
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DATE REC'D BY LOCAL REG. <u>8-15-49</u>		REGISTRAR'S SIGNATURE <u>Sheldine Holmes</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>STINE & MCCLURE CO. KANSAS CITY, MO.</u>		
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WRITE PLAINLY—USING UNEADING BLACK INK—MAKE A PERMANENT RECORD

May E. Meyer

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.

Student
Student Embalmer

Signed.....

May E. Meyer

Licensed Embalmer No. *4555*

P. O. Address *K. E. 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.