

FILED OCT 10 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29894

State File No. \_\_\_\_\_

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

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BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>881</u>	
1. PLACE OF DEATH a. COUNTY <u>GREENE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u>			
b. CITY (If outside corporate limits, write RURAL, and give town) <u>SPRINGFIELD</u>		c. LENGTH OF STAY (in this place) township) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>SPRINGFIELD</u>		39	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>CITY HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>729 W. CHESTNUT</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>JOHN</u>		b. (Middle) <u>H.</u>		c. (Last) <u>FRAILEY</u>	
4. DATE OF DEATH		(Month) <u>Oct</u>		(Day) <u>2</u>		(Year) <u>1949</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWER</u>		8. DATE OF BIRTH <u>JULY 28 1887</u>	
9. AGE (In years last birthday) <u>62</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 M. 12 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LABORER</u>		11. BIRTHPLACE (State or foreign country) <u>ILL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>WIDOWER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>HAROLD FRAILEY, SEDELIA, MO.</u>			
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 (a) <u>Prostatic Hypertrophy</u> ANTECEDENT CAUSES Morbid 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>Exfoliative dermatitis due to pemphigus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 MO</u> <u>610X</u> <u>10 days</u>	
19a. DATE OF OPERATION <u>9-15-49</u>		19b. MAJOR FINDINGS OF OPERATION <u>prostatic Hypertrophy</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)		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 <u>Aug 29</u> , 1949, to <u>Oct-2</u> , 1949, that I last saw the deceased alive on <u>Oct-2</u> , 1949, and that death occurred at <u>2:00A m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Joseph M. Hill</u>				23b. ADDRESS <u>609 Cherry</u>		23c. DATE SIGNED <u>10-3-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10-4-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Hazelwood</u>		24d. LOCATION (City, town, or county) (State) <u>Springfield, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>10-3-49</u>		REGISTRAR'S SIGNATURE <u>W. E. Bradley III</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. W. Klingman Co. Spfld.</u>			

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**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.....

Signed.....  
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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.