

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 30032

BIRTH NO. _____		REG. DIST. NO. <u>140</u>		PRIMARY REG. DIST. NO. <u>5549</u>		Registrar's No. <u>51</u>	
1. PLACE OF DEATH a. COUNTY <u>Howard</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence, before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howard</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>R. R. #2 Richmond</u>		c. LENGTH OF STAY (In this place) <u>6 hrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Richmond</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>R. R. #2 Fayette, Mo.</u>				d. STREET ADDRESS (If rural, give location) <u>R. R. #2 Fayette, Mo</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Noah</u>			b. (Middle) <u>Flood</u>		c. (Last) <u>Frazier</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 25, 1949</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Dec. 2, 1892</u>	9. AGE (In years less birthday) <u>56</u>	IF UNDER 1 YEAR (Months) <u>8</u>	IF UNDER 24 HRS. (Hours) (Min.) <u>25</u>
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Howard Co. Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Barney S. Frazier</u>			13b. MOTHER'S MAIDEN NAME <u>Amanda Jane Williams</u>		14. NAME OF HUSBAND OR WIFE <u>Bertha Clay Rennolds</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY # <u>488-26-4051</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Noah Frazier Fayette, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary heart disease</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>32 months</u> <u>6 months</u> <u>4201</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			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) (m.)		21e. INJURY OCCURRED WHILE AT <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 25, 1949</u> , to <u>Aug 25, 1949</u> , that I last saw the deceased alive on <u>Aug 25, 1949</u> and that death occurred at <u>3 P. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>M. Leach M.D.</u>				23b. ADDRESS <u>Fayette, Mo</u>		23c. DATE SIGNED <u>8-27-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8/27/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>New Hope Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Howard County, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>August 30, 1949</u>		REGISTRAR'S SIGNATURE <u>Mary K. Shell deputy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph A. Carr</u>		ADDRESS <u>Fayette, MO</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

SEP 8

District Health Officer No. 8,

District File Number

Date Filed

9-21-49

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

Ralph A. Cass

Licensed Embalmer No.

3340

P. O. Address

Lafayette 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.