

FILED JAN 28 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3582**

BIRTH NO. _____		REG. DIST. NO. 340		PRIMARY REG. DIST. NO. 4503		Registrar's No. 7	
1. PLACE OF DEATH a. COUNTY Stoddard				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Stoddard			
b. CITY (If outside corporate limits, write RURAL and give township) Bernie		c. LENGTH OF STAY (in this place) 35 yrs		c. CITY (If outside corporate limits, write RURAL and give township) Bernie		1030	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home				d. STREET ADDRESS (If rural, give location) city			
3. NAME OF DECEASED (Type or Print) a. (First) Loren		b. (Middle) Howard		c. (Last) Fritts		4. DATE OF DEATH (Month) (Day) (Year) Jan. 11 1950	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Nov. 7, 1890	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) Months Days 59 2 4		11. BIRTHPLACE (State or foreign country) Illinois	
13a. FATHER'S NAME Sam Fritts		13b. MOTHER'S MAIDEN NAME Mary Laston		14. NAME OF HUSBAND, OR WIFE Edna Fritts			
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.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Edna Fritts Bernie, Mo			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer of the Esophagus 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. Chronic Alcoholism				INTERVAL BETWEEN ONSET AND DEATH Unknown	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 June 13, 1949 , to Jan. 11, 1950 that I last saw the deceased alive on 1-11- , 1950 and that death occurred at 11:30 P. M. , from the causes and on the date stated above.							
23a. SIGNATURE F O Kelley (Degree or title)				23b. ADDRESS 2 Bernie Mo.		23c. DATE SIGNED 1-17-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Buried		24b. DATE Jan. 15 1950		24c. NAME OF CEMETERY OR CREMATORY Bernie Cemetery		24d. LOCATION (City, town, or county) (State) Bernie Missouri	
DATE REC'D BY LOCAL REG. 1-18-50		REGISTRAR'S SIGNATURE Delma N. Jankins		25. FUNERAL DIRECTOR'S SIGNATURE 409		ADDRESS Funeral Home, Campbell, Mo	

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

RECEIVED JAN 24 1954

District Health Office No.

District File Number 150-8

Date Filed

SEP 22 1954

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 Christina M. Landess

Licensed Embalmer No. 4227

P. O. Address Campbell, M

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.