

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43299

DEC 27 1950

State File No. (187) 578  
Registrar's No. 6116

BIRTH NO.		REG. DIST. NO. 333	PRIMARY REG. DIST. NO. 6116			
1. PLACE OF DEATH a. COUNTY SCOTT			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY SCOTT 10-3-0			
b. CITY (If outside corporate limits, write RURAL and give ORN TOWN RURAL 6116 township)		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) RURAL Blodgett		
d. FULL NAME OF HOSPITAL OR INSTITUTION R 7 N # 2 Blodgett			d. STREET ADDRESS (If rural, give location) R 7 N # 2			
3. NAME OF DECEASED (Type or Print) a. (First) GEORGE		b. (Middle) WILLIAM		c. (Last) FREY		
4. DATE OF DEATH 12-17-50		5. SEX M O		6. COLOR OR RACE WHITE		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH Nov 22 1890		9. AGE (in years last birthday) 80		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) St Louis Mo O		
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME HENRY FREY		13b. MOTHER'S MAIDEN NAME JANE GREEN		
14. NAME OF HUSBAND OR WIFE STEPHANIE FREY		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		
17. INFORMANT'S SIGNATURE OR NAME		ADDRESS				
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, asthenia, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PNEUMONIA LOBAR  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) ASTHMA CHRONIC BRONCHIAL  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 6-7 days
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) (Min.)		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 12/17, 1950, to 12/17, 1950, that I last saw the deceased alive on 12/17, 1950, and that death occurred at 2:30 P. m., from the causes and on the date stated above.						
23a. SIGNATURE John M. Collins M.D.			23b. ADDRESS Stallcup Bldg. Sikeston, Mo.		23c. DATE SIGNED 12/19/50	
24a. BURIAL, CREMATION, REMOVAL, REMOVAL 4		24b. DATE 12-21-50		24c. NAME OF CEMETERY OR CREMATORY ST JOSEPH		
24d. LOCATION (City, town, or county) (State) BONNE TERRE MO		25. FUNERAL DIRECTOR'S SIGNATURE Mrs. Ella Klunten		ADDRESS Welsh Funeral Home, Sikeston Mo		
DATE REC'D BY LOCAL REG 12-20-50						

(Licensed Embalmer's Statement on Reverse Side)

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

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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..... Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston Mo

Signed.....  
Student Embalmer

**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.**