

FILED JAN 27 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1119
110 Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (In this place) 45 yrs.		d. STREET ADDRESS (If rural, give location) 1231 Highland	
d. FULL NAME OF HOSPITAL OR INSTITUTION Wheatley Provident			

3. NAME OF DECEASED (Type or Print) Ada Lee Frazier			4. DATE OF DEATH January 6, 1951		
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH May 14, 1880		9. AGE (In years last birthday) 70		10. MONTHS 3 DAYS 10 HOURS 0 MIN.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME John Clark		13b. MOTHER'S MAIDEN NAME Mary Watts		14. NAME OF HUSBAND OR WIFE William F. Frazier	
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. None		17. INFORMANT'S SIGNATURE OR NAME William Frazier ADDRESS 1231 Highland	

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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Apoplexy		INTERVAL BETWEEN ONSET AND DEATH 200X
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis DUE TO (c) Diabetes mellitus		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Malnutrition		

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 **1/4**, 19**51**, to **1/6**, 19**51**, that I last saw the deceased alive on **1/5**, 19**51** and that death occurred at **10:15** a.m., from the causes and on the date stated above.

23a. SIGNATURE L. S. Dangle (Degree or title)		23b. ADDRESS 2122 E. 15th St.		23c. DATE SIGNED 1/8/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1/9/51		24c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery	
				24d. LOCATION (City, town, or county) (State) Kansas City, Missouri	

DATE REC'D BY LOCAL REG. 1-9-51		REGISTRAR'S SIGNATURE Seraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE Watkins Bros. ADDRESS 1729 Lydia	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Dwyer

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *Isaac M. Malone*

Licensed Embalmer No. *3994*

P. O. Address *2503 Highland*

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.