

STANDARD CERTIFICATE OF DEATH

7393

State File No. Registrar's No. 262

FILED MAR 17 1952  
BIRTH NO. 5800

REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Stewartsville	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) Stewartsville	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Osteopathic Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) RICHARD	b. (Middle) ANDREW	c. (Last) FRAKES	4. DATE OF DEATH (Month) (Day) (Year)
				Feb. 25, 1952

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Feb. 23, 1952	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 1 MIN. Min.
					2		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Joseph, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Clifford Frakes	13b. MOTHER'S MAIDEN NAME Leila Bootman	14. NAME OF HUSBAND OR WIFE none
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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. No	17. INFORMANT'S SIGNATURE OR NAME Clifford Frakes	ADDRESS Stewartsville, Mo.
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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		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia		
	INHALATION		
ANTECEDENT CAUSES		DUE TO (b) _____	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) _____	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	7630	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from 22nd, 1952 to 25th, 1952, that I last saw the deceased alive on 25th, 1952, and that death occurred at Lions m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. John Hartsock D.O.	23b. ADDRESS 926 Edmond	23c. DATE SIGNED 2-27-52
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24a. BURIAL-CREMA-TION, REMOVAL (Specify) Burial	24b. DATE Feb. 27, 1952	24c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
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DATE REC'D BY LOCAL REG. MAR. 10, 1952	REGISTRAR'S SIGNATURE Carl C. Cash	446	25. FUNERAL DIRECTOR'S SIGNATURE Earl Clark	120 I ADDRESS Illinois
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1170

Vertical stamp on left margin

**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.....

*Emma Clark*

Signed.....

Student Embalmer

Licensed Embalmer No. *4228*

P. O. Address *St. Joseph 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.