

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19007

State File No.

FILED JUN 2 5 1952

BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 112

1. PLACE OF DEATH a. COUNTY <u>Salina</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Salina</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marshall</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marshall</u> <u>0972</u>	
c. LENGTH OF STAY (In this place) <u>4 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>901 S. English</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>901 S. English</u>			

3. NAME OF DECEASED (Type or Print) a. (First) ERNEST b. (Middle) WARREN c. (Last) FRAKES 4. DATE OF DEATH (Month) (Day) (Year) MAY 30, 1952

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 8. DATE OF BIRTH MAR 21, 1882 9. AGE (In years last birthday) 70 9. AGE (In years last birthday) Months - Days - Hours - Min. -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER - RET 10b. KIND OF BUSINESS OR INDUSTRY Farm Owner 11. BIRTHPLACE (State or foreign country) Boomer, Missouri 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME WILLIAM R. FRAKES 13b. MOTHER'S MAIDEN NAME MADELWE MCCOY 14. NAME OF HUSBAND OR WIFE MATIE KAYE Frakes

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 ADDRESS Leo Hayob, 901 S. English, Marshall, Mo

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES Pulmonary Oedema DUE TO (b) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ Multiple Sclerosis about 15 yrs.

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 345X 20. AUTOPSY? YES NO

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 NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from Aug 19th, 1952, to May 30, 1952, that I last saw the deceased alive on May 29, 1952, and that death occurred at 5:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE Robert Kennedy, M.D. (Degree or title) 23b. ADDRESS Marshall Mo 23c. DATE SIGNED 5-30-52

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 24b. DATE JUNE 1, 1952 24c. NAME OF CEMETERY OR CREMATORY LACLEDE CEMETERY 24d. LOCATION (City, town, or county) (State) LACLEDE, MISSOURI

DATE REC'D BY LOCAL REG. May 30, 1952 REGISTRAR'S SIGNATURE Sidney F Gray 385 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Harold B. Wright, Brookfield, Mo.

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

972
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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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Harold B. Wright

Signed.....

Student Embalmer

Licensed Embalmer No. *3778*

P. O. Address *Brookfield, 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.