

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2153

State File No.

FILED JAN 26 1953

BIRTH NO. _____ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 5698 Registrar's No. 8

0590

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

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sampsel</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Mooresville</u> <u>0590</u>	
c. LENGTH OF STAY (in this place) <u>2 1/2 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Abbie</u> b. (Middle) _____ c. (Last) <u>Frazier</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>January 20, 1953</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED; DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 27, 1860</u>		9. AGE (In years last birthday) <u>92</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Breckenridge, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>

13a. FATHER'S NAME <u>Jerry Bashford</u>		13b. MOTHER'S MAIDEN NAME <u>Mariah</u>		14. NAME OF HUSBAND OR WIFE <u>Amos Frazier</u>	
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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) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Jess Walker; R#3 Chillicothe, Mo.</u>		
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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) <u>Mycarditis</u>			<u>?</u>
		ANTECEDENT CAUSES			
		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 <u>4222</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		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 Dec 28, 1952, to Jan 20, 1953, that I last saw the deceased alive on Dec 28, 1952, and that death occurred at 6:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Joseph F. Gale M.D.</u>		23b. ADDRESS <u>Chillicothe, Mo.</u>		23c. DATE SIGNED	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>1-23-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Gaunt</u>	24d. LOCATION (City, town, or county) (State) <u>Livingston County, Mo.</u>	
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DATE REC'D BY LOCAL REG. <u>1-21-53</u>		REGISTRAR'S SIGNATURE <u>Frances B. New</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Norman Funeral Home; Chillicothe, Mo.</u>	
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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.

Student
Student Embalmer

Signed Elton F. Norman

Licensed Embalmer No. 4036

P. O. Address Chillicothe, 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.