

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24792
3613

State File No. _____
Registrar's No. _____

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1001

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) 38 Yrs.		d. STREET ADDRESS (If rural, give location) 3914 Agnes	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital No. 1			

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Oliver c. (Last) Fredrick		4. DATE OF DEATH (Month) (Day) (Year) 7 20 1953	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 16 Sept. 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucker- self	11. BIRTHPLACE (City and State or Foreign Country) Sweet Home, Missouri
			12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME George Fredrick	13b. MOTHER'S MAIDEN NAME Annie Mc Bride	14. NAME OF HUSBAND OR WIFE Mina B. Fredrick
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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. 490-16-4910 A	17. INFORMANT'S SIGNATURE OR NAME Mrs. Mary M. Milligan	ADDRESS 3914 Agnes K. C. 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac hypertrophy and dilatation		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>		DUE TO (b) Chronic cardiac decompensation		
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		DUE TO (c)		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" 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) (Min.)	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 July 19, 1953, to July 20, 1953, that I last saw the deceased alive on July 20, 1953, and that death occurred at 4:20P m., from the causes and on the date stated above.

23a. SIGNATURE B. I. Burns (Degree or title) M.D.	23b. ADDRESS 24th & Cherry	23c. DATE SIGNED 7-21-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 23 July 1953	24c. NAME OF CEMETERY OR CREMATORY Floral Hills	24d. LOCATION (City, town, or county) (State) Kansas City, Missouri
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DATE REC'D BY LOCAL REG. 7-22-53	REGISTRAR'S SIGNATURE Sheraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Floral Hills Memorial Chapels, . k. C Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Handwritten signature or initials in the top right corner.

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 *By* *Chas C. Mc Neal*

Licensed Embalmer No. *4853*

P. O. Address *K. C. Mc*

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.