

FILED JUN 7 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16568  
State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3092 Registrar's No. 1137

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>Daviess</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chillicothe</u>		c. CITY OR TOWN <u>Gallatin</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Chillicothe Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>0310</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Nettie</u> b. (Middle) <u>Lee</u> c. (Last) <u>Frost</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 2 1954</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>Sept. 27 1873</u>
9. AGE (In years last birthday) <u>80</u>		IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u>	IF UNDER 24 HRS. Hours <u>    </u> Min. <u>    </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Breckenridge, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Scott Hoover</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Jennings</u>	
14. NAME OF HUSBAND OR WIFE <u>Thomas L. Frost, (Dec'd)</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>    </u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Charles Youtsey, Rt. 1, Brookfield, Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>① Jaundice</u> <u>② Bright's disease of kidneys</u>		<u>10 days</u> <u>?</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<u>4222</u>	
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 <u>May 17, 1954</u> , to <u>June 2, 1954</u> , that I last saw the deceased alive on <u>June 2, 1954</u> , and that death occurred at <u>9:30 A. m.</u> , 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 <u>6-2-54</u>		23d. SIGNATURE _____	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>6-4-1954</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Brown Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Gallatin, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>6-2-54</u>		REGISTRAR'S SIGNATURE <u>Frances B. Neill</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>L. C. Richesson</u>		ADDRESS <u>Funeral Home, Gallatin, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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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.....  
Signature of Student Embalmer

Signed *L. O. Richesson*  
Licensed Embalmer No. *73*  
P. O. Address *Salisbury*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.