

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11913**

FILED MAY 16 1955

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. **1821**

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 town) Kansas City		c. LENGTH OF STAY (in this place) 55 yrs.	d. Is Residence within limits of a city or incorporated town? Yes No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 6135 Wyandotte		STREET ADDRESS (If rural, give location) 86 6135 Wyandotte	

3. NAME OF DECEASED (Type or Print) a. (First) LESLIE b. (Middle) C. c. (Last) FRAME		4. DATE OF DEATH (Month) (Day) (Year) April 22, 1955	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 3	8. DATE OF BIRTH Nov. 5, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Consultant - Mo. State Empl. Service		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Cameron, Missouri
13a. FATHER'S NAME James H. Frame		13b. MOTHER'S MAIDEN NAME Emma C. Caldwell	14. NAME OF HUSBAND OR WIFE --

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 191-20-9051	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Mary Fuller, 6135 Wyandotte, 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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 24 hours
	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. Demo fibrosis - R. chest		10 mos.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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 **Feb. 1952**, to **April 22, 1955**, that I last saw the deceased alive on **April 11, 1955**, and that death occurred at **8 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE P. R. Byers	(Degree or title) M.D.	23b. ADDRESS 9635 Wyandotte, K.C. 12, Mo	23c. DATE SIGNED 4/22/55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-25-55	24c. NAME OF CEMETERY OR CREMATORY Mt. Moriah	24d. LOCATION (City, town, or county) (State) Kansas City, Missouri
DATE REC'D BY LOCAL REG. 4-25-55	REGISTRAR'S SIGNATURE Reva Minshall	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STINE & McCLURE UND. CO. K.C. MO.	

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

Mr. Byers of Hillman
Miss W. ...
D. ...
...

Post

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 *Robert G. Boyer*

Licensed Embalmer No. *48*

P. O. Address *K.C. 9*

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.