

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30140

State File No. ....

FILED SEP 23 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 5694 Registrar's No. 167

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>Chillicothe Twp.</u>	c. LENGTH OF STAY (In this place) <u>2 1/2 MIN. approx</u>	c. CITY OR TOWN <u>Chillicothe</u>	4. 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 (If not in hospital or institution, give street address or location) <u>Hiway A 3 MI N.W. of Chillicothe, Mo.</u>		e. STREET ADDRESS (If rural, give location) <u>15 Webster St.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>EDMUND</u>	b. (Middle) <u>SIDNEY</u>	c. (Last) <u>FRAHM</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 17 55</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>17 Oct. 1900</u>	9. AGE (In years last birthday) <u>54</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Dealer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Automotive</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Trosky, Minn.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Dorothy Newman</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>481-07-1753</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Dorothy Frahm Chillicothe, Mo.</u>	ADDRESS _____
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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) <u>Confusion of Heart. Severe</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Few Minutes</u>
ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>	DUE TO (b) _____		
	DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>	<u>Fractured Skull</u>		<u>Few Minutes</u>

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Country road</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Chillicothe, Livingston, Mo</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Sept. 17 '55 9:00 a.m.</u>	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Pt hit approach to bridge (hit rail)</u>
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22. I hereby certify that I attended the deceased from none 1955, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on Sept. 17, 1955, and that death occurred at 9 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Joseph A. Conrad M.D. (Coroner)</u>	23b. ADDRESS <u>Chillicothe, Mo.</u>	23c. DATE SIGNED <u>Sept. 20-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>9-19-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Wheeling Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Wheeling (Liv Co) Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Sept 20-55</u>	REGISTRAR'S SIGNATURE <u>Frances B. Neill</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>NORMAN FUNERAL HOME</u>	ADDRESS <u>Chillicothe, Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

SEP 30 1955

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 *Edwin Norman*

Licensed Embalmer No 4036..

P. O. Address..Chillicothe

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.