

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12809

State File No. ....

FILED MAY 2 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 99 PRIMARY REG. DIST. NO. 4168 Registrar's No. 26

1. PLACE OF DEATH a. COUNTY <u>Dekalb</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Davies</u>	
b. CITY OR TOWN <u>Maysville</u>		c. CITY OR TOWN <u>Gallatin</u>	
c. LENGTH OF STAY (in this place) <u>3 Yrs 7 Mo</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>Hill Crest Nursing Home</u>		e. STREET ADDRESS (If rural, give location) <u>2310</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Annie</u>	b. (Middle) <u>Gay</u>	c. (Last) <u>Frazier</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April 26 1956</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, <input checked="" type="checkbox"/> WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 15 1873</u>	9. AGE (In years last birthday) <u>83</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>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Rappahannock Co. Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Jack Houghton</u>	13b. MOTHER'S MAIDEN NAME <u>Ellen Houghton</u>	14. NAME OF HUSBAND OR WIFE <u>Thomas W. Frazier (Decd)</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 <u>Owen Frazier, Gallatin, 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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>yes?</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> 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>331X</u>	20. AUTOPSY? YES <input 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 March, 1955, to April 26, 1956 that I last saw the deceased alive on April 26, 1956 and that death occurred at 4:30A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Dr. Harold Fowler MD</u>	23b. ADDRESS <u>Maysville, Mo</u>	23c. DATE SIGNED <u>4/27/56</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>4-29-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Brown Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Gallatin, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>4-30-56</u>	REGISTRAR'S SIGNATURE <u>Roslyn Davidson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>L. O. Kishison</u>	ADDRESS <u>Hope Funeral Home, Gallatin, Mo.</u>
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(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. Richardson*.....  
Licensed Embalmer No. *336*

P. O. Address *Dallat*.....

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.