

Health,  
Wellfare  
Public  
Service

STANDARD CERTIFICATE OF DEATH

28480  
STATE FILE NUMBER

FILED AUG 22 1957

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 403

1. PLACE OF DEATH a. COUNTY <b>JASPER</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JASPER</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JOPLIN</b>		c. CITY OR TOWN <b>JOPLIN</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>FREEMAN HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>1817 BYERS AVE.</b>	
Length of stay in 1b <b>24 YRS</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle Last <b>FEAR</b>			4. DATE OF DEATH Month <b>AUGUST</b> Day <b>19</b> Year <b>1957</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 8, 1895</b>
9. AGE (In years last birthday) <b>62</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED-MANAGER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>J. NEWBERRY Co.</b>	11. BIRTHPLACE (City and state or country) <b>KINGMAN, KANSAS</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>GEORGE FEAR</b>	
13b. MOTHER'S MAIDEN NAME <b>FANNY TEMPLE</b>		14. NAME OF HUSBAND OR WIFE <b>MRS. ANNA G. FEAR</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNK</b>	17. INFORMANT Address <b>MRS. ANNA G. FEAR, 1817 BYERS AVENUE</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage (Multiple)</b>			INTERVAL BETWEEN ONSET AND DEATH <b>May 1, 1957</b> <b>Aug. 18 1957</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>331X</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hypertensive arterio sclerotic cardiovascular syndrome 12 yrs. duration</b>			
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION <b>JOPLIN</b>		20f. COUNTY <b>JASPER</b> STATE <b>MISSOURI</b>	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21. I attended the deceased from <b>April 1, 1957</b> to <b>Aug. 19, 1957</b> and last saw <sup>her</sup> him alive on <b>Aug. 18, 1957</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>Bobble Star Sr MD</i> (Degree or title)		22b. ADDRESS <b>410 Jackson, Joplin, Mo.</b>	
22c. DATE SIGNED <b>8-19-57</b>		23a. NAME OF CEMETERY OR CREMATORY <b>WALNUT HILL CEMETERY,</b>	
23b. DATE <b>8-23-57</b>		23d. LOCATION (City, town, or country) (State) <b>KINGMAN; KANSAS</b>	
23c. REMOVAL (Specify) <b>REMOVAL</b>		24. FUNERAL DIRECTOR ADDRESS <b>STEVE PARKER MORTUARY, JOPLIN, MO.</b>	
25. DATE RECD. BY LOCAL REG. <b>8-20-1957</b>		26. REGISTRAR'S SIGNATURE <i>Noice Merriam</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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ADD 20 1951  
Date Filed

APR 9 9 1951

FEB 11 1951

SEP 19 1951

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 *F. M. Jones* .....

Licensed Embalmer No. *2319* .....

P. O. Address *Joplin* .....

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.