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 health, Welfare Public Service
 300
 1-56
 All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
 doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
 1911

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED SEP 16 1957

STANDARD CERTIFICATE OF DEATH

31187

STATE FILE NUMBER

Registration District No. 73 Primary Registration District No. 5291 Registrar's No. 110

1. PLACE OF DEATH a. COUNTY <u>Clay</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Liberty, Mo.</u> <u>5</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Kansas City,</u> <u>3078</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Odd Fellows Hosp</u>		Length of stay in 1b <u>30 Yrs</u>	d. STREET ADDRESS (If outside, give location) <u>105 So Hardesty</u>		
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Newton</u> Last <u>Fry</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>29</u> Year <u>1957</u>		
5. SEX <u>Male</u> <u>0</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <u>2</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 11 1872</u>	9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Marion, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Jacob Fry</u>			14. MOTHER'S MAIDEN NAME <u>Martha P. Tolbert</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Mrs Clyde O. Thorp (daughter) Kas. City, Mo.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4500</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <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 _____ a. m. _____ p. m. _____			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>1957</u> to _____ and last saw <u>her</u> alive on <u>Aug 29</u> Death occurred at <u>Aug 29</u> <u>9</u> P. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Wm J. Graham MD</u> (Degree or title)			22b. ADDRESS <u>Liberty, Mo</u>		22c. DATE SIGNED <u>8/30/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Aug 31 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Mrs C.L. Forster Funeral Home Inc.</u> <u>Kansas City, Missouri.</u>			25. DATE RECD. BY LOCAL REG. <u>Sept. 7-1957</u>	26. REGISTRAR'S SIGNATURE <u>Mabel Graham</u>	

(Licensed Embalmer's Statement on Reverse Side)



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 *J. Virgil Stearns*

Licensed Embalmer No. 35

P. O. Address *ACE*

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