Health, Welfare Public Service

300 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED OCT 3 1957

STATE FILE NUMBER 33109

Registration District No. 314 Primary Registration District No. 6059 Registrar's No. 53

1. PLACE OF DEATH
a. COUNTY St. Clair
b. CITY OR TOWN Collins (If outside corporate limits, give TOWNSHIP only) Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Collins Township Length of stay in Ib

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Clair
c. CITY OR TOWN Collins Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) Collins Township Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First John Middle David Last Frye

4. DATE OF DEATH Month Sept Day 15 Year 1957

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH May 16, 1891

9. AGE (In years last birthday) 66 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) Log Buyer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Marysville Iowa

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME John A. Frye

13b. MOTHER'S MAIDEN NAME Synia Ann Hall

14. NAME OF HUSBAND OR WIFE Deceased

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown) Yes (If yes, give war or dates of service) WW # 1

16. SOCIAL SECURITY NO. 500-36-5287

17. INFORMANT Irvin Frye, Address Collins Missouri

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH sudden
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) 4201

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 5-8-57 to 9-15-57 and last saw her/him alive on
Death occurred at 6:00 A.M on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Dr. E. D. Brown (Degree or title)

22b. ADDRESS Collins Mo

22c. DATE SIGNED 9-18-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 9/20/57

23c. NAME OF CEMETERY OR CREMATORY Hamilton

23d. LOCATION (City, town, or county) Hamilton (State) Iowa

24. FUNERAL DIRECTOR Goodrich Home ADDRESS Osceola Mo

25. DATE RECD. BY LOCAL REG. 9-18-1957

26. REGISTRAR'S SIGNATURE Ruth Bowers

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

OCT 3 1957

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. B. Goodrich

Licensed Embalmer No. 3038

P. O. Address Osceola N

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.