

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-024142
State File No.

FILED JUL 11 1958

REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 1677

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

1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis		
b. CITY (If outside corporate limits, write RURAL and give township) Manchester		c. LENGTH OF STAY (in this place) 10 yrs.	c. CITY (If outside corporate limits, write RURAL and give township) Manchester 40006		d. STREET ADDRESS (If rural, give location) Route 1 Box 52
d. FULL NAME OF HOSPITAL OR INSTITUTION Route 1 Box 52					
3. NAME OF DECEASED a. (First) PEARL		b. (Middle)	c. (Last) FRAZIER	4. DATE OF DEATH (Month) (Day) (Year) June 19, 1958	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 27, 1895	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR: Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (City and State or Foreign Country) Independence, Kansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Jim Williams		13b. MOTHER'S MAIDEN NAME Alice	14. NAME OF HUSBAND OR WIFE Grover Frazier		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Grover Frazier Manchester, Mo.		
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Damage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 1 year + 7. years
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 443x				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7-29- , 19 57 , to 6-19- , 19 58 , that I last saw the deceased alive on 6-13 , 19 58 , and that death occurred at 7 m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Robert Kaplan M.D.			23b. ADDRESS 607 N Grand	23c. DATE SIGNED 6-20-58	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6/23/58	24c. NAME OF CEMETERY OR CREMATORY Clayton Rd. Cemetery	24d. LOCATION (City, town, or county) (State) Manchester, Mo.		
DATE REC'D BY LOCAL REG. 6-23-58	REGISTRAR'S SIGNATURE Herbert R. Drake M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Charles J. Gates	ADDRESS 4107 Finney Av.	

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
Student Embalmer

Signed Houston Swan

Licensed Embalmer No. 4580

P. O. Address 4107 Finney Avenue

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 this body is not embalmed, fact should be so stated above.