

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-044101

STATE FILE NUMBER

FILED JAN 14 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6178

300
-57 1

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR Kansas City TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 8200 E. 67th Street		Length of stay in lb 10 years	d. STREET ADDRESS (If outside, give location) 8200 E. 67th Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last MR. CON STANTINE (CON) FRAZIER			4. DATE OF DEATH Month Day Year December 28, 1958		
---	--	--	--	--	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1894	9. AGE (In years last birthday) 64	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) President, Con-Frazier	10b. KIND OF BUSINESS OR INDUSTRY Buick Company	11. BIRTHPLACE (City and state or country) Ash Grove, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
--	---	--	--

13a. FATHER'S NAME Constantine Frazier	13b. MOTHER'S MAIDEN NAME Sarah A. Simmons	14. NAME OF HUSBAND OR WIFE Ellen Doran Frazier
--	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) Yes W. W. # 1	16. SOCIAL SECURITY NO. 495-05-3058	17. INFORMANT Address Mrs. Ellen D. Frazier - 8200 E. 67th Street
--	---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis		INTERVAL BETWEEN ONSET AND DEATH 2 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Adeno-Carcinoma of the Sigmoid	2 1/2 yrs.
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1533		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.) 1533
---	---

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT <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 8-6 AM to 12-28-58 and last saw him alive on 12-27-58 . Death occurred at 1:00 PM on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE W. M. Ketcham MD (Degree or title)	22b. ADDRESS KC Mo	22c. DATE SIGNED 12/29/58
--	---------------------------	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec. 30, 1958	23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
--	-----------------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS Stine & McClure Und. Co., K.C., Missouri	25. DATE RECD. BY LOCAL REG. 12-29-58	26. REGISTRAR'S SIGNATURE New Marshall
---	---	--

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

W. M. Ketcham

017-0100
2 PM



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 *Ray Jones*

Licensed Embalmer No. *5010*

P. O. Address *K.C., Mo.*

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.