Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004646

STATE FILE NUMBER

FILED MAR 16 1959 Registration District No. 042 Primary Registration District No. ——— Registrar's No. 255

1. PLACE OF DEATH a. COUNTY Buchanan	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Agency — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN Agency 0116 — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) — Length of stay in lb life	d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print)	First: FRAZIER	Middle: W.	Last: DOWELL	4. DATE OF DEATH Month Day Year: March 7, 1959
5. SEX: male	6. COLOR OR RACE: white	7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH: Oct. 5, 1889	9. AGE (In years last birthday): 69 — 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): Ret. farmer	10b. KIND OF BUSINESS OR INDUSTRY: farm	11. BIRTHPLACE (City and state or country): Agency, Mo.	12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME: Ben Dowell	13b. MOTHER'S MAIDEN NAME: Nannie Farris	14. NAME OF HUSBAND OR WIFE: Bessie L.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: unknown	17. INFORMANT Address: Mrs. Bessie L. Dowell, Agency, Mo.		

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 myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: at once

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary occlusion — at once

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4281

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

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. 130 Month, Day, Year 3-7-59

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home

20f. CITY, TOWN, OR LOCATION: Agency Mo — COUNTY: Buchanan — STATE: MO

21. I attended the deceased from Viewed body and last saw her/him alive on 3-7-59

Death occurred at 1:30p. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): S E Meluney MD

22b. ADDRESS: 214 Kirkpatrick Bldg St. Joseph Mo

22c. DATE SIGNED: 3-10-59

23a. BURIAL, CREMATION, REMOVAL (Specify): burial	23b. DATE: 3/9/1959	23c. NAME OF CEMETERY OR CREMATORY: Agency Cemetery	23d. LOCATION (City, town, or county) (State): Agency Missouri
24. FUNERAL DIRECTOR: Heaton-Bowman	ADDRESS: St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG.: Mar. 13 1959	26. REGISTRAR'S SIGNATURE: Mrs. Clarke Gardell

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 John V. Henrickson

Licensed Embalmer No. 4848

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.