

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008727
STATE FILE NUMBER

Registration District No. 393 Primary Registration District No. 1002 Registrar's No. 1504

APR 8 1959

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>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Goshland Kansas City</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Goshland Kansas City</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>108 Dixie</u> Length of stay in Mo. <u>3 Mo.</u>		d. STREET ADDRESS (If outside, give location) <u>108 Dixie</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>L.</u> Last <u>Frazier</u>			4. DATE OF DEATH Month <u>Mar.</u> Day <u>23</u> Year <u>1959</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-18-80</u>	9. AGE (In years last birthday) <u>78</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13a. FATHER'S NAME <u>Robert Frazier</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret Routh</u>	14. NAME OF HUSBAND OR WIFE _____	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT <u>Mrs. Dwight James, Gashland, Mo.</u> Address _____
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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>Malnutrition</u> <u>Cancer of Stomach</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>undetermined</u>
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. Month, Day, Year _____	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 10-1-58 to 3-10-59 and last saw ^{her} _{him} alive on 3-10-59
Death occurred at 7:10 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or title) <u>Lawrence H. Hayes M.D.</u>	22b. ADDRESS <u>8400 N Oak Truff.</u>	22c. DATE SIGNED <u>3-23-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>3-24-59</u>	23c. NAME OF CEMETERY OR CREMATORY _____	23d. LOCATION (City, town, or county) (State) <u>Buffalo, Missouri</u>
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24. FUNERAL DIRECTOR <u>R. A. Fulton, Kansas City, Kansas</u> ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>3-23-59</u>	26. REGISTRAR'S SIGNATURE <u>Reva Minshall</u>
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(Licensed Embalmer's Statement on Reverse Side)

LAWRENCE H. HAYES USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

APR 8 1953

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 *Ralph Fulton*

Licensed Embalmer No. *3035*

P. O. Address *K.C.K.*

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.