THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-021356

STATE FILE NUMBER

FILED JUL 13 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3115

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kansas City — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Marys Hosp. — Length of stay in 1b: 50 YRS.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Kansas
b. COUNTY: Johnson
c. CITY OR TOWN: LEAWOOD — Inside Limits: Yes [ ] No [ ]
d. STREET ADDRESS (If outside, give location): 9629 Lee Blvd. — Reside on Farm: Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First: Odessa — Middle: M — Last: Fraker

4. DATE OF DEATH: Month: June — Day: 25 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: MAY 9, 1878

9. AGE (In years last birthday): 81 yrs. — 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): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): MARYSVILLE, MO.

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: WILLIAM M. DRUMM

13b. MOTHER'S MAIDEN NAME: MARY LYNCH

14. NAME OF HUSBAND OR WIFE: LEE D. FRAKER

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.: 496 05 2937

17. INFORMANT: MRS. JAMES L. BARRICK — Address: 9627 LEE BLVD.

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) Endocarditis, acute — INTERVAL BETWEEN ONSET AND DEATH: approx 6 wks.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Staphylococcus aureus

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 4301

19. WAS AUTOPSY PERFORMED? YES [X] 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 6-5-59, to 6-25-59 and last saw her/him alive on 6-25-59. Death occurred at 3:20 PM. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: W J Stelmach (Degree or title) M.D.

22b. ADDRESS: 7951 State Line

22c. DATE SIGNED: 6/26/59

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

23b. DATE: JUNE 29, 1959

23c. NAME OF CEMETERY OR CREMATORY: FOREST HILL CEM

23d. LOCATION (City, town, or county) (State): KANSAS CITY, MO.

24. FUNERAL DIRECTOR — ADDRESS: D.W. Newcomers Sons Kansas City, Mo.

25. DATE RECD. BY LOCAL REG.: 6-26-59

26. REGISTRAR'S SIGNATURE: Neva Marshall

W. J. Stelmach

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Norman W. Thorson

Licensed Embalmer No. 4889

P. O. Address N. C., N.O.

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.