

S. Health,  
& Welfare  
S. Public  
th Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-026647  
STATE FILE NUMBER

FILED VS JUL 24 1959

2 6465

Registration District No. Primary Registration District No. Registrar's No.

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v. 1-57  
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57 2

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>ST. LOUIS, MO.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL #1.</b>		Length of stay in 1b	d. STREET ADDRESS <b>1635 LOVEJOY LANE</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>( BABY BOY ) KEVIN ANTHONY FRAZIER</b>			4. DATE OF DEATH <b>6 - 27 - 1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/27/59</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days <b>7 2 4</b> IF UNDER 24 HRS. Hours Min. <b>2 4</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>ROBERT L. FRAZIER</b>		13b. MOTHER'S MAIDEN NAME <b>MAYROSE MARTIN</b>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>ST. LOUIS CITY HOSP. #1.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>congenital atelectasis</b> DUE TO (b) <b>prematurity</b> DUE TO (c) <b>762.5</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
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 Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT <input type="checkbox"/> 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 <b>6-27-1959</b> to <b>6-27-1959</b> and last saw her alive on <b>6-27-1959</b> Death occurred at <b>10:00 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22. SIGNATURE (Degree or title) <b>R. James Vaccarella, M.D.</b>			22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>		22c. DATE SIGNED <b>6-27-1959</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>7-31-59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
24. FUNERAL DIRECTOR <b>Rowland Aker 4104 Manchester</b>		25. DATE RECD. BY LOCAL REG. <b>JUL 9 59</b>		26. REGISTRAR'S SIGNATURE <b>Loard Smith, M.D.</b>	

(Licensed Embalmer's Statement on Reverse Side)

mjc

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 .....

Licensed Embalmer No. ....

P. O. Address .....

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.