

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029087

**FILED VS SEP 1 1959 149**

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. 3917

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>JACKSON</u> b. CITY (If outside corporate limits, give TOWNSHIP and Length of stay in 1b OR TOWN <u>Independence</u> <u>20 yrs</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>8735 MORRELL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>JACKSON</u> c. CITY OR TOWN <u>Independence</u> *Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>8735 MORRELL</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <u>JESSE</u> Middle <u>C</u> Last <u>FRIZELL</u>			<b>4. DATE OF DEATH</b> Month <u>Aug</u> Day <u>11</u> Year <u>1959</u>		
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> (Age last birthday) <u>3-8-1876</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RET. FARMER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farm</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>ORCHID MISSOURI</u>	
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>		<b>13a. FATHER'S NAME</b> <u>ROBERT FRIZELL</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>MARY Mc FARLAND</u>	
<b>14. NAME OF HUSBAND OR WIFE</b> <u>Lydia A. FRIZELL</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>487-14-9135</u>	
<b>17. INFORMANT</b> <u>MRS Lydia A. FRIZELL</u> Address <u>Independ. Mo.</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric Hemorrhage</u> DUE TO (b) <u>Gastric Ulcer</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>17 hrs</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE

**21. I attended the deceased from** August 1958 to August 11 1959 and last saw him alive on August 10 1959  
 Death occurred at 2:30 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>Robert R Tonkens D.O.</u>	<b>22b. ADDRESS</b> <u>8218 Winner Rd</u>	<b>22c. DATE SIGNED</b> <u>8/10/59</u>
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE</b> <u>8-13-1959</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>FLORAL HILL CEMETERY</u>
<b>23d. LOCATION</b> (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>		<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Kansas City, Mo.</u> DATE RECD. BY LOCAL REG. <u>8-12-59</u>
<b>26. REGISTRAR'S SIGNATURE</b> <u>New Marshall</u>		

**24. FUNERAL DIRECTOR** ADDRESS Kansas City, Mo. DATE RECD. BY LOCAL REG. 8-12-59

**26. REGISTRAR'S SIGNATURE** New Marshall

BY AFFIDAVIT OF DOCUMENT MEDICAL CERTIFICATION Robert R. Tonkens

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

~~or by~~ \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Forrest D. Coldman

Licensed Embalmer No. 4714

P. O. Address J. 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.