

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-001661

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 442 STATE FILE NUMBER

AMENDED

FILED FEB 13 1962

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Length of stay in 1b <u>30 Yrs</u>	c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1800 JEFFERSON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1800 JEFFERSON</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>EDMOND FRAZIER</u>			4. DATE OF DEATH Month Day Year <u>JANUARY 21, 1962</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/18/96</u>	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR <u>65 Yrs</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CUSTODIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>APT. BUILDING</u>		11. BIRTHPLACE (City and state or country) <u>WALLACE, IA.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
14. NAME OF HUSBAND OR WIFE <u>IZEDA D. FRAZER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>WW1 WW1</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Jackson County Coroner Office</u>			

18. CAUSE OF DEATH (Enter only one cause per line following) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> DUE TO (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I <u>Senility</u>		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

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 Month, Day, Year <u>Hour</u>		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 _____ to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degrees or title) <u>Deputy Coroner</u>		22b. ADDRESS <u>1618 Lydia Ave</u>		22c. DATE SIGNED <u>1/21/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1/29/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>FT. LEAVENWORTH, KANS.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>MRS. MEEK'S MORTUARY K.C. MO.</u>		25. DATE RECD. BY LOCAL REG. <u>1-25-62</u>	26. REGISTRAR'S SIGNATURE <u>Auth Song</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 M. Tillman
 BY AFFIDAVIT OF
 SHOULD READ
 ITEM NO.

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 William B. Parker

Licensed Embalmer No. 5013

P. O. Address KC 712

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.