

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-005235

STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 11

AMENDED

FILED JAN 30 1962

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Cedar</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington TWP</u>		Length of stay in 1b <u>14 9 Mo 9 da.</u>	c. CITY OR TOWN <u>Eldorado Springs</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>State Hosp. #3</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>224 W. Spring</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>John B. Fry</u>			4. DATE OF DEATH Month Day Year <u>1 21 62</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> <u>Unk</u> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-6-76</u>
9. AGE (last birthday) <u>85</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>	11. BIRTHPLACE (City and state or country) <u>Morris Co. Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>W.N. Fry</u>	
13b. MOTHER'S MAIDEN NAME <u>Mary J. ?</u>		14. NAME OF HUSBAND OR WIFE <u>unk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk</u>		16. SOCIAL SECURITY NO. <u>unk</u>	17. INFORMANT <u>Records</u> Address <u>State Hospital #3 Nevada Mo</u>
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>Bronchopneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 do</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u>			<u>unk</u>
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Brain Syndrome associated w Senile disease</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 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 <u>9:45</u> to <u>1-21-62</u> at <u>10:05 AM</u> and last saw her/him alive on <u>1-21-62</u> Death occurred at <u>9:45</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Jill Combs MD</u> (Degree or title)		22b. ADDRESS <u>Nevada Missouri</u>	22c. DATE SIGNED <u>1-21-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1/22/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wash. Univ. Sch of Med</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
24. FUNERAL DIRECTOR <u>Richard L. Shorten, Nevada, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>Jan 23-1962</u>	26. REGISTRAR'S SIGNATURE <u>Armal E. Ferry</u>

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

**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. 4853

P. O. Address Florida, 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.