

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-002802

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 47

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|  |                            |  |  |
|--|----------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Pittsburg</u>  |                            | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MO</u> b. COUNTY <u>Morgan</u>  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>   |                            | Length of stay in 1b <u>6 weeks</u>  | c. CITY OR TOWN <u>Atterville</u>  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sedalia Rest Home</u>   |                            | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location) <u>8 miles S of Atterville</u> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES - ALBERT - FRY</u>  |                            | 4. DATE OF DEATH Month Day Year <u>Feb. 5, 1963</u>  |  |
| 5. SEX <u>male</u>   | 6. COLOR OR RACE <u>wh</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>   | 8. DATE OF BIRTH <u>May 5, 1877</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>  |                            | 10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>  | 11. BIRTHPLACE (City and state, county) <u>Shreve Haute, Ind.</u>            |
| 13. FATHER'S NAME <u>James M. Fry</u>  |                            | 14. NAME OF HUSBAND OR WIFE <u>Bertha Louise Fry</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war and date of service)  |                            | 16. SOCIAL SECURITY NO. <u>no</u>  |  |
| 17. INFORMANT  |                            | 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>bronchopneumonia</u><br>DUE TO (b) _____<br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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  |                            | 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>Dec 1962</u> to <u>Feb 5 1963</u> and last saw him alive on <u>Jan 4 1963</u><br>Death occurred at <u>3:30 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated. |                            |  |  |
| 22a. SIGNATURE (Degree or title) <u>John Brazor M.D.</u>   |                            | 22c. DATE SIGNED <u>2/6/63</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Feb 7, 1963</u>  |                            | 23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F Home</u>   |  |
| 24. FUNERAL DIRECTOR <u>Hays - Painter, Atterville, MO</u>   |                            | 25. DATE RECD. BY LOCAL REG. <u>Feb. 7, 1963</u>   |  |
| 26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>  |                            | 27. ADDRESS <u>Atterville, MO</u>  |  |

USE BLACK INK OR TYPEWRITER RIBBON

**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

*Robert L. Painter*

Licensed Embalmer No.

*4069*

P. O. Address

*Pilot Grove, 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.