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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 20 1946

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2281

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

10047

1. **PLACE OF DEATH:**
   (a) County
   (b) City or town St. Louis, Mo. (If outside city or town limits, write "RURAL" and name of township)
   (c) Name of hospital or institution: Park Lane Hospital (If not in hospital or institution, write street number or location)
   (d) Length of stay: In hospital or Institution 9 days (Specify whether In this community 14 years years, months or days)

2. **USUAL RESIDENCE OF DECEASED:**
   (a) State Missouri (b) County
   (c) City or town St. Louis (If outside city or town limits, write "RURAL")
   (d) Street No. 4332 Maryland Ave. (If rural, give location)
   (e) Citizen of foreign country? No. (Yes or No)
   If yes, name country

3. (a) PRINT FULL NAME Bessie Frazier
   3. (b) If veteran, name war No.
   3. (c) Social Security No. No.
   4. Sex F.
   5. Color or race W.
   6. (a) Single, widowed, married, divorced Married
   6. (b) Name of husband or wife Elihu Emory Frazier
   6. (c) Age of husband or wife if alive 61 years
   7. Birth date of deceased May (Month) 7 (Day) 1884 (Year)

8. **AGE:** Years 61 Months 9 Days 29 If less than one day hr. min.

9. Birthplace Sullivan County, Mo. (City, town, or county) (State or foreign country)
10. Usual occupation At Home
11. Industry or business

FATHER
12. Name John Harmon
13. Birthplace Sullivan County, Mo. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Alred
15. Birthplace Lynn County, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. P. P. DeWitt
    (b) Address 1137 81st St. University City
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 3-9/46 (Month) (Day) (Year)
    (c) Place: burial or cremation Oak Grove
18. (a) Signature of funeral director Alexander Sonnebe
    (b) Address 6175 Delmar
19. (a) MAR 8 1946 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month March day 6 year 1946 hour 2:30 minute P.M.
21. I hereby certify that I attended the deceased from ~~illness~~ last 1st 1945 to March 6th 1946 that I last saw her alive on March 6th 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	2 days
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
    (a) Accident, suicide, or homicide (specify)
    (b) Date of occurrence
    (c) Where did injury occur? (City or town) (County) (State)
    (d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
    While at work? (e) Means of injury
23. Signature Clyde B. Kane M.D. (M. D. or other)
    Address 706 Walton Date signed 3-7-46

(Licensed Embalmer's Statement on Reverse Side)

W. Clyde Kane
706 Walton
RO 1666

1-3
4-5
8-10

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Jos. E McCulloch

Licensed Embalmer No. 2460

P. O. Address 6175 Delmar

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 this body is not embalmed, fact should be so stated above.