MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

20012

1 PLACE OF DEATH JUL 28 1926

County Linn

Township Jefferson
or
Village
or
City (NO. St.; Ward)

Registration District No. 500 File No.

Primary Registration District No. 5665 Registered No. 7

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME William R Frakes

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Jan (Month) 25 (Day), 1844 (Year)

7 AGE 81 yrs. 5 mos. 29 ds. If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer) Farming

9 BIRTHPLACE (City or town, State or foreign country) Perry Co Ind

PARENTS

10 NAME OF FATHER John Frakes

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ind.

12 MAIDEN NAME OF MOTHER Nancy P Brown

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas Frakes

(Address) Sumner, Mo R.F.

15 Filed 6/24/26, 191 F. W. Burke Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June (Month) 24 (Day), 1926 (Year)

17 I HEREBY CERTIFY, that I attended deceased from May 16, 1926, to June 24, 1926, that I last saw him alive on June 24, 1926, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Influenza
Complicated with
Chronic Parenchymatous
Nephritis (Duration) 129 yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J W Hardy M. D.

June 24 1926 (Address) Sumner Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Laclede Cem DATE OF BURIAL June 26, 1926

20 UNDERTAKER Hunter & Rawlins ADDRESS Brookfield Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write the word*)

6 DATE OF BIRTH

..... 1.....
(Month) (Day) (Year)

7 AGE .....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or .....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... 191.....
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from .....191....., to .....191.....

that I last saw h.....alive on ....., 191.....

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs.....mos.....ds.

(Signed) .....M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS