

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

Do not use this space.

39523

**1. PLACE OF DEATH**

County Jackson  
Township Jackson  
City Warrens City (No. 1108)

Registration District No. 3000  
Primary Registration District No. 807

File No. 5096  
Registered No. 5096  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Wm. B. Frisbey  
(a) Residence No. 2102 G. 27<sup>2</sup> St. 4 Ward \_\_\_\_\_  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

M

**4. COLOR OR RACE**

wh.

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

Married.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

August 28 - 1868

**7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

62.

3

20.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Printer.

(b) General nature of industry, business, or establishment in which employed (or employer) Retired.

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Missouri

PARENTS

**10. NAME OF FATHER** Wm. Frisbey.

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)** Ohio  
(STATE OR COUNTRY)

**12. MAIDEN NAME OF MOTHER** Mary R. O'Neill.

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)** Ill.  
(STATE OR COUNTRY)

**14. INFORMANT** W. B. Frisbey.  
(Address) Delia. R. Frisbey.

**15. FILED** 12/19/30 M. M. Crowe  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** 12-18-1930

**17. I HEREBY CERTIFY, That I attended deceased from** Dec. 17, 1930, to Dec. 18, 1930  
that I last saw him alive on Dec. 17, 1930, and that death occurred, on the date stated above, at 10 a m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

pernicious anemia  
71A

(duration) 2 yrs. mos. ds.

**CONTRIBUTORY (SECONDARY)**

(duration) \_\_\_\_\_ yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

**8 DID AN OPERATION PRECEDE DEATH?** DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical  
(Signed) Alberts. Leach, M. D.

1/8, 1930 (Address) 835 Riado Bldg.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** Topeka, Kans. **DATE OF BURIAL** 12-19-1930

**20. UNDERTAKER** J. H. O'Donnell **ADDRESS** 1256 Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

