

REC'D JUN 9 1938

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

17706  
Do not use this space.

1. PLACE OF DEATH *Boone* 7  
(a) County *Columbia* Registration District No. *73*  
(b) Township *Columbia* Primary Registration District No. *5112* Registered No. *108*  
(c) City ..... (d) Street No. ....  
(If death occurred in Hospital or Institution, write its name instead of street and number) St.  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *George W. Frost. 62.9*  
(a) Residence, No. .... St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Charlie Frost.*  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *2-14-1861*  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
*77 2 2*

OCCUPATION  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Farmer*  
9. Industry or business in which work was done, as saw mill, bank, etc. *Farmer*  
10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....  
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*  
FATHER  
13. NAME *Charles Frost.*  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*  
MOTHER  
15. MAIDEN NAME *Adaline Davis*  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Don't know.*  
17. INFORMANT (ADDRESS) *Auntie Frost. Columbia Mo. RFD 6*  
18. BURIAL, CREMATION, OR REMOVAL PLACE *New Providence* DATE *5-8-38*  
19. FUNERAL DIRECTOR (ADDRESS) *W.H. Vandewenter. Columbia Mo.*  
20. FILED *5/7/1938* *Allie Selby* Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *5-6-1938*  
22. I HEREBY CERTIFY, That I attended deceased from *4-27* 1938, to *5-27* 1938.  
I last saw him alive on *5-4-1938*. Death is said to have occurred on the date stated above, at *5A* m.  
The principal cause of death and related causes of importance were as follows:  
*Paralysis*  
Date of onset

Other contributory causes of importance:  
*Chronic Dyspepsia*

Name of operation ..... Date of .....  
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. ....

Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....  
If so, specify .....  
(Signed) *S. Williamson* M. D.  
*74* (Address) *Columbia Mo.*

N. B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATEMENT BY LICENSED EMBALMER

I, W. H. Daudel Licensed Embalmer No. 2494

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_  
working under my personal supervision.

Registered Apprentice No. \_\_\_\_\_

Signed

W. H. Daudel

Licensed Embalmer No. 2494

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

17706

Do not use this space.

1. PLACE OF DEATH

(a) County Boone Registration District No. 73  
 (b) Township Columbu Primary Registration District No. 5112 Registered No. 108  
 (c) City..... (d) Street No..... St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME George W. Frost

(a) Residence, No. .... St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
77 2 2

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER  
 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER  
 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-6, 1938

22. I HEREBY CERTIFY, That I attended deceased from Apr 27 to Apr 27, 1938

I last saw him alive on Apr 27, 1938. Death is said to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

Paralysis cerebral  
Chronic Dysentery  
 Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) F. B. Williamson, M. D.

(Address) Columbu

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

1938  
S-17706