

REC'D FEB 20 1939

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

1381
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township Ray Primary Registration District No. 1002 Registered No. 394
(c) City N. C. Mo. (d) Street No. General Hospital #2 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

(a) Residence, No. 1026 John Henry Frazier
1975 Garfield (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Coloured 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5-14-1938
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
8 12

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
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) Mo.

FATHER 13. NAME John Frazier
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Okl.

MOTHER 15. MAIDEN NAME Eliza Stewart
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Okl.

17. INFORMANT (ADDRESS) Record Clerk General Hospital

18. BURIAL, CREMATION, OR REMOVAL PLACE Lincoln Cemetery DATE 1-30-1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Thos Appleton Jones
1905 Olive St

20. FILED Jan 30 1939 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-26-1939

22. I HEREBY CERTIFY, That I attended deceased from 1-22-1939 to 1-26-1939

I last saw him alive on 1-26-1939 Death is said to have occurred on the date stated above, at 5:45 a.m.
The principal cause of death and related causes of importance were as follows:

Date of onset

Spasmodic
1070

Other contributory causes of importance:

Broncho Pneumonia

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

What test confirmed diagnosis?..... Was there an autopsy? no

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) J. A. Brown M. D.(Address) General Hospital #2

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 _____

Licensed Embalmer No. 2710

P. O. Address _____

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, above space should be left blank.