

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22116

Registration District No. 460 Primary Registration District No. 5-1-244 Registrar's No. _____

1. PLACE OF DEATH:
(a) County Lafayette
(b) City or town Aullville, Mo.
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9
In this community 30yrs
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Edward Lee Frazier 626
3. (b) If veteran, name war no 3. (c) Social Security No. 486-09-4773

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, Married
6. (b) Name of husband or wife Virgil Mae Frazier 6. (c) Age of husband or wife if alive 48 years
7. Birth date of deceased Oct-14-1887
(Month) (Day) (Year)

8. AGE: Years 52 Months 7 Days 21 If less than one day _____ hr. _____ min.

9. Birthplace Dover, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation in factory

MOTHER FATHER
11. Industry or business _____
12. Name Wm. Henry Frazier
13. Birthplace Dover Mo.
14. Maiden name Annie Eliza Petty
15. Birthplace Dover Mo. Dayton Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Virgil Mae Frazier
(b) Address Aullville, Mo.

17. (a) Burial (b) Date thereof 6-7-1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Higginsville, Mo.

18. (a) Signature of funeral director Walter Meinershager
(b) Address Higginsville, Mo.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Lafayette
(c) City or town Aullville Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June-5-1940
year _____ hour 9-45 minute _____ P _____ M.

21. I hereby certify that I attended the deceased from Jan 1940
to June 5 1940
that I last saw him alive on June 5 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Valvular heart disease
decompensation - over 4 mo.

Due to _____
Due to 9.2 W

Other conditions _____
(Includes pregnancy within 3 months of death)

PHYSICIAN
Major findings: four fingers amputated (left hand)
Of operations Oct 5-1939
Of autopsy _____
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? 413

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

28. Signature W. E. Kappenberg (M. D. certifying) _____
Address Higginsville, Mo. Date signed 6/7/40

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

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

Roy F. Wiegman

Licensed Embalmer No. *2883*

P. O. Address *Higginsville, Mo.*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 82116

Registration District No. 460

Primary Registration District No. 5624 A

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Darius T. P.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Edward Lee Fragner

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

19. DATE OF DEATH June 5
month _____ day _____
year _____ hour _____ minute _____ M.

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

20. I hereby certify that I attended the deceased from _____ 19____, to _____ 19____;
that I have seen him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

8. AGE: Years Months Days If less than one day

52 7 21 hr. _____ min.

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

Major findings:
Of operations _____

Of autopsy _____

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) 8-3-1990 (b) T. J. Young Webb
(Date received local registrar) (Registrar's signature)

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?
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature W. E. Kepper (M, D. or other) _____
Address Braytonville Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

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