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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 1941

Registration District No. 1

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1

State File No. 37665

Registrar's No. 317

1. PLACE OF DEATH:
(a) County: Adair
(b) City or town: Kirksville (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Grim Smith Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 hours (Specify whether years, months or days) In this community Born in Schuyler Co.

2. USUAL RESIDENCE OF DEACESED:
(a) State: Mo (b) County: Schuyler 98
(c) City or town: Lancaster (Rural) B 0 (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: EDWYNA FRADY
3. (b) If veteran, name war: 0
3. (c) Social Security No.: 0
4. Sex: FE
5. Color or race: Wh
6. (a) Single, widowed, married, divorced: S W
6. (b) Name of husband or wife: 0
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Sept (Month) 7 (Day) 1929 (Year)

8. AGE: Years	Months	Days	If less than one day
12	2	6.	0 hr. 0 min.

9. Birthplace: Schuyler Co (City, town, or county) U Mo (State or foreign country)
10. Usual occupation: Student
11. Industry or business:
FATHER 12. Name: Harvey Frady
FATHER 13. Birthplace: Schuyler Co (City, town, or county) U Mo (State or foreign country)
MOTHER 14. Maiden name: Lena Marten
MOTHER 15. Birthplace: Schuyler Co (City, town, or county) U Mo (State or foreign country)
16. (a) Informant: Mrs Clarence Marten
(b) Address: Schuyler Co Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 14/41 (Month) (Day) (Year)
(c) Place: burial or cremation: Lancaster, Mo
18. (a) Signature of funeral director: Po Fenton
(b) Address: Lancaster, Mo
19. (a) Nov. 13/41 (Date received local registrar) (b) Spencer L. Freeman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 13 year 1941 hour 9 minute 30 a M.
21. I hereby certify that I attended the deceased from Nov 13, 1941, to Nov 13, 1941; that I last saw her alive on Nov 13, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia
Due to: Streptococcosis
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations: None done
Of autopsy: Not done

Duration

PHYSICIAN — 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? (Specify type of place)
While at work? (e) Means of injury: 0
23. Signature: E. B. Smith (M. D. or other)
Address: Kirksville Date signed 11/13/41

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 12-41-2088
Date Filed DEC 3 1941

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 O. Fenton

Licensed Embalmer No. 3785

P. O. Address Lancaster

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

If this body is not embalmed, fact should be so stated above.

No. 2B
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37665

Registration District No. 1 Primary Registration District No. 1 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kirksville
(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 years, months or days)
In this community

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Edwyna Grady
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive, years
7. Birth date of deceased Sept. (Month) 1 (Day) 1929 (Year)
8. AGE: Years 12 Months 2 Days If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. Day 3 year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Pneumonia
Due to Bronchial Streptococcus
Due to Septicemia
Due to Infected area (blister) on right heel pressure from ill fitting shoe
Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations 24a
Of autopsy

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

23. Signature E. Sanborn Smith (M. D. or other)
Address Kirksville Date signed 1/8/42

SUPPLEMENTARY