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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 284

Primary Registration District No. 200

Registrar's No. 338

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

1. PLACE OF DEATH:

(a) County St. Louis, Missouri

(b) City or town ELLISVILLE  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Copley Nursing Home 4  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. None  
(If rural, give location)

(e) Citizen of foreign country?.....  
If yes, name country.....

3. (a) PRINT FULL NAME John Riley Frazee

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Zena Belle Frazee

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

7. Birth date of deceased January 7, 1848  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>85</u>	<u>1</u>	<u>1</u>	..... hr. .... min.

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

10. Usual occupation Retired Farmer

11. Industry or business.....

12. Name Unknown Frazee

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

14. Maiden name Jane Hammock

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

16. (a) Informant Mary Jane Herman

(b) Address 1404 Graham Street.

17. (a) Burial (b) Date thereof 2/11/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston, Missouri

18. (a) Signature of funeral director Albert H. Hoppe, Inc

(b) Address 4700+ Washington Blvd.

19. (a) FEB 10 1943 (b) C. R. McFarlan, M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 8th  
year 1943 hour..... minute..... M.

21. I hereby certify that I attended the deceased from 1-27-43  
....., 19....., to 2-8....., 1943.

that I last saw him alive on 2-6....., 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Acute Cardiac dilatation 1 day

Due to Chronic Myocarditis 2 yrs

Due to Arteriosclerosis 2 yrs

Other conditions Pyodermia acuta 2 days  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:  
Of operations.....

Of autopsy 938

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?

While at work..... (Specify type of place)

(c) Means of injury.....

23. Signature C. R. McFarlan, M.D. M. D. or other.....  
Address 209 So Kirkwood Rd. Date signed 2/10/43

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**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

*G. W. Wilkinson*

Licensed Embalmer No. 3575

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, fact should be so stated above.**