

No. 2
5-43
5-17-39
X3667

FILED JUN 28 1944
Registration District No. _____

Primary Registration District No. 3056

State File No. _____

Registrar's No. 137

1. PLACE OF DEATH:

(a) County Randolph

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

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

(d) Length of stay: In hospital or institution 30 minutes
(Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Macon '61

(c) City or town Macon '3
(If outside city or town limits, write "RURAL") '2

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

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

3. (a) PRINT FULL NAME Warren H. Frazier

3. (b) If veteran, name war _____

3. (c) Social Security No. 702-05-8216

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 11th
year 1944 hour 2 minute 30 P.M.

21. I hereby certify that I attended the deceased from June 11, 44, 1944, to June 11, 1944, 1944
and that I last saw him alive on June 11, 1944
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race W

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

6. (b) Name of husband or wife Gertrude Frazier 6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased July 10, 1905
(Month) (Day) (Year)

Immediate cause of death: unknown

Duration: _____

8. AGE: Years 39 Months 11 Days 1 If less than one day hr. _____ min. _____

Due to: unknown

Due to: _____

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

10. Usual occupation Telegraph Operator

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

Major findings: Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name James Frazier

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

14. Maiden name Armine Roberts 9

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

16. (a) Informant Mr. Bertie Frazier 1
(b) Address Macon, Mo.

17. (a) Burial (b) Date thereof 6-13-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Morrisville Mo

18. (a) Signature of funeral director Stephus Gooding

(b) Address Macon, Mo.

19. (a) 6-13-44 (b) Orma Kave
(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 Eric Handley 0 (M. D. or other)
Address Wabash Hospital Moberly Date signed 6-12-44

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

3688

3

MOTHER FATHER

POST 87 NDC

RECEIVED

District Health Officer No. 10

District File Number 6-44-1198

Date Filed JUN 27 1944

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.....

C. L. Stephens

Licensed Embalmer No. 3057

P. O. Address.....

Marion, 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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. 1371

Registration District No. 294 Primary Registration District No. 3056

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

1. PLACE OF DEATH: Randolph
 (a) County moderly
 (b) City or town _____
 (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 _____ years, months or days
 3. (a) PRINT FULL NAME Warren H. Jeger
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 10 1900
 (Month) (Day) (Year)

8. AGE: Years 39 Months 11 Days _____ If less than one day _____ min.
 9. Birthplace _____ (City, town, or county) (State or foreign country) mo

10. Usual occupation _____
 11. Industry or business _____

MOTHER FATHER { 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)

16. (a) Informant _____ (b) Address _____
 17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
 (Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____ (b) Address _____
 19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July Year 1944 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____
 that I last saw him alive on July 11 1944
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Due to Heart failure
 Due to Tuberculosis of lungs
 Other conditions _____ (Include pregnancy within 3 months of death)

PHYSICIAN _____
 Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
 Of autopsy: 1371

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 Eric Hansen (M. D. or other) _____
 Address Modery Mo Date signed _____

SUPPLEMENTAL

22308