

FILED SEP 8 1944
318

Primary Registration District No. 1003

Registrar's No. 7249

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number of location)
(d) Length of stay: In hospital or institution 5 1/2 Hrs.
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 12
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 9
(d) Street No. 6207 S. Broadway
(If rural, give location) 1
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Robert Frazier
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced 0
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 8 4 44
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 8 day 4
year 44 hour 1 minute 20 -P.M.
21. I hereby certify that I attended the deceased from 8 - 4
19 44 to 8 - 4, 19 44
that I last saw him alive on 8 - 4, 19 44
and that death occurred on the date and hour stated above.

8. AGE: Years _____ Months _____ Days _____ If less than one day 6 hr. 20 min.
9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

Immediate cause of death Bronchopneumonia Duration _____
Due to Unknown
Due to Unknown
Other conditions (include pregnancy within 3 months of death) _____

10. Usual occupation _____
11. Industry or business _____
MOTHER FATHER { 12. Name Charles Irvie Frazier
13. Birthplace Cairo Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Minnie Louise Rucker
15. Birthplace Cairo Illinois
(City, town, or county) (State or foreign country)
16. (a) Informant Walter M. Sherard R.R. Co. M. Duwall
(b) Address 2601 N. Whittier Street
17. (a) Burial (b) Date thereof AUG 24 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation CITY CEMETERY

Major findings: Of operations _____
Of autopsy As above
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

18. (a) Signature of funeral director James Owens
(b) Address City Health Dept
19. (a) AUG 23 1944
(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 J. F. Budeck (M. D. or other) _____
Address 2601 N. Whittier St. Date signed 8-21-44

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

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.....

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.