

No. 2
1-5-43
5-17-39
I X36671

State File No. _____
Registrar's No. 155

NEW JUL 9 1945
Registration District No. _____

Primary Registration District No. 3000

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: Community Nursing Home
(If not in hospital or institution, write street number of location)

(d) Length of stay: In hospital or institution 29 days
Specify whether

In this community _____
years, months or days)

3. (a) PRINT FULL NAME Grover Cleveland Frazier

3. (b) If veteran, name war World War I

3. (c) Social Security No. _____

4. Sex M race W

5. Color or race W

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

6. (b) Name of husband or wife Mattie Frazier

6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased 3 15 1885
(Month) (Day) (Year)

8. AGE: Years 60 Months 3 Days 3 If less than one day _____ hr. _____ min.

9. Birthplace Lynchburg W. Va.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name Don't know

13. Birthplace Don't know
(City, town, or county) (State or foreign country)

14. Maiden name Angelique Don't know

15. Birthplace Don't know
(City, town, or county) (State or foreign country)

16. (a) Informant Mattie Frazier

(b) Address Kirksville Mo.

17. (a) Burial (b) Date thereof 6-20-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Price Cemetery

18. (a) Signature of funeral director Wm E. Hunt & Son

(b) Address Green City, Mo.

19. (a) 6-22-45 (b) Mrs. L. Wagner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Sullivan ¹⁰⁵

(c) City or town Rural ¹
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? No ¹ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 18
year 1945 hour 11 minute 25 A. M.

21. I hereby certify that I attended the deceased from May 25
1945 to June 18 1945
that I last saw him alive on June 18 1945
and that death occurred on the date and hour stated above.

Immediate cause of death myocardial failure ^{3 days}

Due to Hypertensive Heart Disease ^{years}

Due to chronic nephritis

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

Major findings: _____

Of operations _____

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 M. T. Lutenscher or other Dr.
Address Kirksville, Mo. Date signed 6-24-45

RECEIVED

District Health Officer No. 10

District File Number 7-45-1222

Date Filed JUL 7 1922

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.

EMERALD

Signed Archibald Wade

Licensed Embalmer No. 3037

P. O. Address Greenleaf, 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.