

S. No. 2
1-12-45
7-5-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9070
State File No. _____
Registrar's No. 1060

FILED MAR. 21 1947

Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
3417 Montgall /
(If not in hospital or institution, write street number or location)

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

In this community all his life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 3417 Montgall 8
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME William Fraser

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 Jane Fraser

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

7. Birth date of deceased April 9 1855
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>91</u>	<u>10</u>	<u>25</u>	hr. _____ min. _____

9. Birthplace Chicago Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Patrolman

11. Industry or business Kansas City Police Dept.

MOTHER FATHER {

12. Name John W. Fraser

13. Birthplace London England
(City, town, or county) (State or foreign country)

14. Maiden name Bridget Flynn

15. Birthplace Dublin Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Robert Jones

(b) Address 3417 Montgall

17. (a) Burial (b) Date thereof 3 10 48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys

18. (a) Signature of funeral director Melody McGilley Eylar

(b) Address 1800 E Linwood Blvd.

19. (a) 3-8-47 (b) Alfredine Holm
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 8
year 1947 hour 2 minute 30 A. M.

21. I hereby certify that I attended the deceased from 1940
_____, 19____, to Mar. 7, 1947
that I last saw him alive on Mar. 7, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death myocardial failure Duration 3 days

Due to Chronic myocarditis several years

Due to _____

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

Major findings: 93

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? _____

While at work? _____ (Specify type of place) _____
(c) Means of injury _____

23. Signature Alfredine Holm (M. D. or other) _____
Address 1800 E Linwood Blvd Date signed 3/8/47

