V. S. No. 2
00M—5-43
ev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 29 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24864

Registration District No. 217 Primary Registration District No. 5787 Registrar's No. 79

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town Charleston (Rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Route 2, Box 337
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ——— (Specify whether
In this community 25 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi 67
(c) City or town Charleston (Rural)
(If outside city or town limits, write "RURAL")
(d) Street No. Route 2, Box 337
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ———

3. (a) PRINT FULL NAME Mollie Frazier

3. (b) If veteran, name war ——— 3. (c) Social Security No. ———

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased October 4, 1869 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
77	9	4	hr. min.

9. Birthplace Macon, Georgia (City, town, or county) (State or foreign country)

10. Usual occupation Midwife

11. Industry or business ———

FATHER
12. Name Del Jones
13. Birthplace Georgia (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Georgia (City, town, or county) (State or foreign country)

16. (a) Informant Mr. Lonnie Frazier
(b) Address Charleston, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 13, 1947 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director F. J. Sparks
(b) Address Cape Girardeau, Missouri

19. (a) 7-13-47 (Date received local registrar) (b) Mrs. John Bondurant (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8
year 1947 hour 5 minute 45 A. M.

21. I hereby certify that I attended the deceased from 6-21-, 1947 to 7-2-, 1947
that I last saw her alive on 7-2-, 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypertensive Heart Disease c̄ Left Hemiplegia	4 mons. (History)
Due to	
Due to Arteriosclerosis	8 mons (History)
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 0

23. Signature W. A. Fingal (M. D. ~~another~~)
Address 204 S. Locust St. Charleston Mo. Date signed 7-12-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 247-1012
Date Filed 7-28-47

JUL 30 1947

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 Frank Sparks

Licensed Embalmer No. 3255

P. O. Address Cape Girardeau 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.