

FILED DEC 26 1947

Registration District No. **149**

Primary Registration District No. **1002**

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: **Trinity Lutheran Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **since 12-3-47**
(Specify whether
In this community **as above**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **54**
(c) City or town **Lexington** **3**
(If outside city or town limits, write "RURAL")
(d) Street No. **2**
(If rural, give location)
(e) Citizen of foreign country? **no.** (Yes or No)
If yes, name country **X**

3. (a) PRINT FULL NAME **George Frazier**

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

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Mrs. Delia Walter** 6. (c) Age of husband or wife if alive **57** years

7. Birth date of deceased **February 6 1889**
(Month) (Day) (Year)

8. AGE: Years **58** Months **10** Days **5** If less than one day
hr. min.

9. Birthplace **Lexington, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Coal Miner**

11. Industry or business **X**

12. Name **Joseph Frazier**

13. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)

14. Maiden name **Belle Gates**

15. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Delia Frazier**

(b) Address **Lexington, Mo.**

17. (a) **removal** (b) Date thereof **12-11-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lexington, Mo.**

18. (a) Signature of funeral director **Stine & McClure**

(b) Address **3235 Gillham Plaza, K. C., Mo.**

19. (a) **12-12-47** (b) **Heraldine Holmes**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec. 11** 1947 day
year **8-AM** hour minute M.

21. I hereby certify that I attended the deceased from **Dec. 3** 1947 to **Dec. 11** 1947
that I last saw him alive on **Dec. 11** 1947
and that death occurred on the date and hour stated above.

Immediate cause of death **Uremic Coma** Duration

Due to **Uremic Coma**
Left kidney - 12. Maximal stone
in right kidney - one obstructing
causing hydronephrosis

Other conditions
(Include pregnancy within 3 months of death)

Major findings: **Hydronephrosis (high)** PHYSICIAN
Of operations **right side - pyelogram**
Of autopsy **same** 1340
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? _____ (c) Means of injury _____
23. Signature **W. B. Norman** (M. D. or other)
Address **Trinity Hospital** Date signed _____

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

DEC 17 1941

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..... Robert H Reed.....

Licensed Embalmer No. 3745.....

P. O. Address..... J.C. M.....

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.