

FILED MAR 20 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8288

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 228

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. LENGTH OF STAY (in this place) 32 Yrs	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1866 North Grant		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield	
		d. STREET ADDRESS (If rural, give location) 1866 North Grant	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) Chauncey	b. (Middle) Ray	c. (Last) Fraker	March 12 1950		

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 4, 1893	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Capt Fire Station	10b. KIND OF BUSINESS OR INDUSTRY City Fire Dept	11. BIRTHPLACE (State or foreign country) Buffalo, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Henry Fraker	13b. MOTHER'S MAIDEN NAME Alice Tucker	14. NAME OF HUSBAND OR WIFE Agnes Fraker
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Mrs Agnes Fraker, Springfield, Mo.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) probably coronary occlusion		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		UNATTENDED BY A PHYSICIAN	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased _____, 19____, and that death occurred at 8:30 Am., from the causes and on the date stated above.

23a. SIGNATURE W. E. Handley M.D. Local Registrar of Vital Statistics	23b. ADDRESS City Hall Springfield Mo	23c. DATE SIGNED 3/12/1950
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE March 14, 1950	24c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	24d. LOCATION (City, town, or county) (State) Springfield, Mo.
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DATE REC'D BY LOCAL REG. 3-13-50	REGISTRAR'S SIGNATURE W. E. Handley M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Alma Lehmeier, Springfield, Mo.	ADDRESS B. F. W.
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AUG 2 1950

MAR 21 1950

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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

J. Alan Goodrum

Licensed Embalmer No. *H. 562*

P. O. Address

Springfield V

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.