

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. **23863**

**FILED JUL 23 1952**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **55** PRIMARY REG. DIST. NO. **3011** Registrar's No. **60**

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

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Carroll</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Carrollton</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural R.F.D. #3.</b>	
c. LENGTH OF STAY (in this place) <b>2 days</b>		d. STREET ADDRESS (If rural, give location) <b>West of Carrollton Mo.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Bales Hospital</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Emma</b>	b. (Middle) <b>J.</b>	c. (Last) <b>Frazier</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>7-17-52</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Dec. 13, 1889</b>	9. AGE (In years last birthday) <b>62</b>	IF UNDER 1 YEAR Days <b>7</b>	IF UNDER 24 HOURS Hours <b>4</b>	IF UNDER 2 HRS. Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeping</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>House work</b>	11. BIRTHPLACE (State or foreign country) <b>#3. West of Carrollton R.F.D.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>William Riley Frazier</b>	13b. MOTHER'S MAIDEN NAME <b>Margaret Simpson</b>	14. NAME OF HUSBAND OR WIFE <b>Not Married</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT'S SIGNATURE OR NAME <b>A.A. Frazier</b>	18. ADDRESS <b>Carrollton Mo. R.F.D.</b>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>7-15-52</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Fracture of right femur</b>		
	ANTECEDENT CAUSES Malnutrition - hypertension Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) <b>4 angina pectoris</b> DUE TO (c) <b>degenerative changes in coronary arteries</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Oral repairs - E9030 20</b>			

19a. DATE OF OPERATION <b>7-16-52</b>	19b. MAJOR FINDINGS OF OPERATION <b>Scripts complete from rt. femur</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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) <b>Carrollton Carroll Mo.</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>7-15-52 a.</b>	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR <b>Fall on floor</b>
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22. I hereby certify that I attended the deceased from **7-15-1952** to **7-17-1952**, that I last saw the deceased alive on **7-17-1952**, and that death occurred at **8 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Deceased or title) <b>Emma Frazier</b>	23b. ADDRESS <b>Carrollton Mo.</b>	23c. DATE SIGNED <b>7-18-52</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>7-19-52</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Beaty Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>West of Carrollton Mo.</b>
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DATE REC'D BY LOCAL REG. <b>7/19/52</b>	REGISTRAR'S SIGNATURE <b>Mr. Herbert Calvert</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Marshall Funeral Home</b>	ADDRESS <b>Carrollton Mo.</b>
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**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 R. M. Marshall

Licensed Embalmer No. 2525

P. O. Address Carrollton Md

**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.