

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

FILED SEP 9 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **26954**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **201** PRIMARY REG. DIST. NO. **5736** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Macon</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY <b>Macon</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Atlanta Lyka 2090</b>	c. LENGTH OF STAY (in this place) <b>2090</b>	c. CITY OR TOWN <b>Atlanta RFD</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Died at Home</b>		e. STREET ADDRESS (If rural, give location) <b>R&amp;D #1</b> <span style="float: right;">0610</span>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Vessie</b> b. (Middle) <b>Eretta</b> c. (Last) <b>Frages</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Aug 25 1955</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>April 10 1886</b>	9. AGE (In years) (last birthday) <b>69</b>	10. UNDER 1 YEAR Months <b>4</b> Days <b>15</b>	11. UNDER 1 WEEK Hours <b>15</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>General farm work</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Knob. Co. Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Samuel S. Frages</b>	13b. MOTHER'S MAIDEN NAME <b>Martha Boon</b>	14. NAME OF HUSBAND OR WIFE <b>Alice Walker Frages</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>177X</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Weldon Frages</b>	ADDRESS <b>Atlanta Mo</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>3 mo</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Ca of Prostate</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Generalized Ca of</b> DUE TO (c) <b>Bone Tumor, lungs.</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Congestive Heart Failure</b>		?	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>177X</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	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 **Aug 8**, 1954, to **Aug 25**, 1955 that I last saw the deceased alive on **Aug 24**, 1955, and that death occurred at **4:20 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>O. L. Nordwood 2nd</b>	23b. ADDRESS <b>Atlanta Mo</b>	23c. DATE SIGNED <b>Aug 26 55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Aug 27 55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>La Plata Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>La Plata Mo</b>
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DATE REC'D BY LOCAL REG. <b>Aug. 30 1955</b>	REGISTRAR'S SIGNATURE <b>Mrs O. B. Jeffrey</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>H M Goodding</b>	ADDRESS <b>Atlanta Mo</b>
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RECEIVED 9.7.55  
MACON COUNTY HEALTH DEPARTMENT  
County File No. 9.55.154  
Date Filed 9.8.55

(U)

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.....  
Signature of Student Embalmer

Signed..... *H M Goodwin*

Licensed Embalmer No. *1750*

P. O. Address *Atlanta*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.