

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED FEB 8 1957

1577

STATE FILE NUMBER

Registration District No. 154 Primary Registration District No. 5575 Registrar's No. 7

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Washington Twship</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Kansas City Washington Twship</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>202 Maiden Lane</b>			Length of stay in 1b <b>30 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>202 Maiden Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle <b>FRAZIER</b> Last <b>FRAZIER</b>			4. DATE OF DEATH Month <b>1</b> Day <b>31</b> Year <b>57</b>		
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>Wh</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-24-1860</b>	9. AGE (In years last birthday) <b>96</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>XX</b>	11. BIRTHPLACE (City and state or country) <b>San Marcos, Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>No Record</b>			14. MOTHER'S MAIDEN NAME <b>No Record</b>		
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>None</b>	17. INFORMANT Address <b>Mrs. Ruth Abbiatti, K.C. Mo.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Dyscarditis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>4221</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2-3 years</b> <b>Synow</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>2-2-50</b> to <b>1-31-57</b> and last saw her alive on <b>1-28-57</b> Death occurred at <b>2:30 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (De signer or title) <b>Dr. R. Byers M.D.</b>			22b. ADDRESS <b>4635 1/2 W. 4th St., K.C. Mo.</b>		22c. DATE SIGNED <b>2/1/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>1-31-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>LaCygne, Kansas</b>
24. FUNERAL DIRECTOR ADDRESS <b>Wagner Funeral Home, K.C. Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>2-1-57</b>	26. REGISTRAR'S SIGNATURE <b>Dorling Hodder</b>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

FE 1-5 685  
FEB 7 1957

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 *Alvin R. Hansen*.....

Licensed Embalmer No. *41*

P. O. Address *K. C.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.