

Health,  
Welfare  
Public  
Service

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-56

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

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUN 17 1957

20115

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 632

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>St. Joseph</b> <b>0117</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>DOA Sisters Hosp.</b>			Length of stay in 1b <b>Most Life</b>			d. STREET ADDRESS <b>2822 Mary St.</b> (If outside, give location)	
Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>CLARENCE</b> Middle <b>E.</b> Last <b>FRAKES</b>				4. DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>1957</b>			
5. SEX <b>Male</b> <input type="checkbox"/>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 5, 1913</b>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <b>43</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Watson Bros. Tspn.</b>			11. BIRTHPLACE (City and state or country) <b>Halls Missouri</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Nath Frakes</b>				14. MOTHER'S MAIDEN NAME <b>Joan McCoy</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Year, no. or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>491-09-0744</b>		17. INFORMANT <b>Mrs. Matilda Frakes</b> Address <b>St. Joseph, 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>Bleeding cerebral vessels + Shock</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Skull fracture</b>							
DUE TO (c) <b>Automobile turned over truck skidded on ramp, roof, crashed into bridge</b>						<b>about 1 hour</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input checked="" 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.) <b>Due to speed car left highway on curve skidded on ramp, roof, crashed into bridge</b>					
20c. TIME OF INJURY <b>3:30</b> <b>6 7 57</b>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>on highway</b>		20f. CITY, TOWN, OR LOCATION <b>St. Joseph</b> COUNTY <b>MO</b> STATE <b>MO</b>	
21. I attended the deceased from <b>breath</b> to <b>day</b> <b>June 7-57</b> and last saw him alive on <b>June 7-57</b> Death occurred at <b>3:30</b> <b>p</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>S. M. Coroner Buchanan</b> (Degree or title) <b>Cluney Mo.</b>				22b. ADDRESS <b>214 Rutland</b> <b>St. Joseph, Mo.</b>		22c. DATE SIGNED <b>6-8-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>June 10, 1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Joseph Missouri</b>	
24. FUNERAL DIRECTOR <b>St. Joseph Funeral Home</b> ADDRESS <b>St. Joseph, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>June 12, 1957</b>		26. REGISTRAR'S SIGNATURE <b>Toether M. Allison</b>	

(Licensed Embalmer's Statement on Reverse Side)

MAY 28 1958

JUN 18 1957

AUG 26 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 *Charles E. Bennett*

Licensed Embalmer No. *116*

P. O. Address *St. Joseph*

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.