

Health, & Welfare  
Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34870

STATE FILE NUMBER

FILED NOV 4 1957

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1171

300 D  
1-57

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 checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Joseph</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>Mo. Meth. Hosp.</b>		Length of stay in 1b <b>61 years</b>	d. STREET ADDRESS (If outside, give location) <b>2820 Lafayette</b> Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Grover</b> Middle <b>A.</b> Last <b>Fry</b>			4. DATE OF DEATH Month <b>October</b> Day <b>26</b> Year <b>1957</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1887</b>
9. AGE (In years last birthday) <b>70</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>trainman</b>	11. BIRTHPLACE (City and state or country) <b>Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Joseph A. Fry</b>	13b. MOTHER'S MAIDEN NAME <b>Eliza Snapp</b>
14. NAME OF HUSBAND OR WIFE <b>Margaret E. Fry</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>707-05-7694</b>
17. INFORMANT <b>Mrs. Grover Fry, 2820 Lafayette, 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>Acute Post. Coronary Artery Disease</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (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>4201</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 _____ a.m. _____ p.m.	
20d. INJURY OCCURRED WHILE AT <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 <b>St. Joseph, Mo.</b>		20g. COUNTY <b>Buchanan</b>	
20h. STATE <b>Missouri</b>		21. I attended the deceased from <b>4-22-57</b> to <b>10-26-57</b> and last saw him alive on <b>10-26-57</b> Death occurred at <b>8:20 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <b>Robert W. Kiehl, M.D.</b>		22b. ADDRESS <b>St. Joseph, Mo.</b>	
22c. DATE SIGNED <b>10-28-57</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	
23b. DATE <b>10/28/1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	
23d. LOCATION (City, town, or county) <b>St. Joseph, Mo.</b>		23e. STATE <b>Missouri</b>	
24. FUNERAL DIRECTOR <b>Heaton-Bowman</b>		25. DATE RECD. BY LOCAL REG. <b>Oct. 31, 1957</b>	
26. REGISTRAR'S SIGNATURE <b>Mrs. Robert Fulton</b>		(Licensed Embalmer's Statement on Reverse Side)	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

8  
0

3711

1951

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 *William Felding* \_\_\_\_\_  
Licensed Embalmer No. *4535* \_\_\_\_\_  
P. O. Address *3145 R. E. [unclear]* \_\_\_\_\_

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.