

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-002510

FILED VS. JAN 14 1960 209

Primary Registration District No. 3043 Registrar's No. 3

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Marion</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Levering Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u> c. CITY OR TOWN <u>Hannibal</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1611 Harrison Hill</u> Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EDWIN</u> Middle <u>H.</u> Last <u>FRAZER</u>			4. DATE OF DEATH Month <u>January</u> Day <u>1</u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>December 17, 1884</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>_____</u> Min. <u>_____</u> IF UNDER 24 HR Hours <u>_____</u> Min. <u>_____</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Internal Revenue</u>		11. BIRTHPLACE (City and state or country) <u>Hannibal Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13a. FATHER'S NAME <u>Dr. George Frazer</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Priest</u>		14. NAME OF HUSBAND OR WIFE <u>Jean Tomlinson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>es</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Hal Frazer Hannibal Missouri</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric Thrombosis</u> DUE TO (b) <u>Cardiac Decompensation</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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. Month, Day, Year _____							
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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE			
21. I attended the deceased from <u>24 Dec 1951</u> , to <u>1 Jan 1960</u> and last saw ^{her} / _{him} alive on <u>1 Jan 1960</u> • Death occurred at <u>4:30 A.</u> _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Myrtle Hamlin M.D.</u>			22b. ADDRESS <u>Hannibal Mo.</u>		22c. DATE SIGNED <u>1/4/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1/4/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Barkley Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>New London Missouri</u>		
24. FUNERAL DIRECTOR ADDRESS <u>W. Crawford Smith Hannibal Missouri</u>			25. DATE RECD. BY LOCAL REG. <u>1-6-1960</u>		26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Deckerly</u> <u>Lillian Herman</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 4540

P. O. Address Hannibal Missou

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.