SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-020089
STATE FILE NUMBER

AMENDED

Registration District No. 336 Primary Registration District No. 336 Registrar's No. 108

FILED JUN 7 1961

1. PLACE OF DEATH
a. COUNTY Shannon
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Winona
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION In City of Winona
Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Shannon
c. CITY OR TOWN Winona
Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location)
Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Harriet Middle Ann Last Frazier
4. DATE OF DEATH Month May Day 25 Year 1961
5. SEX Female
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH 4-8-1874
9. AGE (last birthday) 87
IF UNDER 1 YEAR Months Days
IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Housewife
11. BIRTHPLACE (City and state or country) Fort Payne, Ala.
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME J.P. Morgan
13b. MOTHER'S MAIDEN NAME Amelia Davidson
14. NAME OF HUSBAND OR WIFE James Baine Frazier
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT May Belle Wolfe Address Winona, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EMPYSEMA
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) LOBAR PNEUMONIA
DUE TO (c)
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 MAY 5-61, to MAY-25-61 and last saw her/him alive on MAY 25-1961
Death occurred at 9 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE H. A. Rollins (Degree or title) MD
22b. ADDRESS Winona Mo
22c. DATE SIGNED 6-1-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 5-27-1961
23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery
23d. LOCATION (City, town, or county) Winona (State) Mo.

24. FUNERAL DIRECTOR Ernest E. Clary ADDRESS Box 398, Winona, Mo
25. DATE RECD. BY LOCAL REG. 6-5-1961
26. REGISTRAR'S SIGNATURE Mabel Gall

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | 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 me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Ernest E. Clary

Signature of Student Embalmer

Licensed Embalmer No. 5118

P. O. Address Box 348, Winona, Mo.

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.