

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-0C1577

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 456

FILED FEB 8 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS (INSTEAD OF)

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

H. H. Owens

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Length of stay in 1b <u>46 yrs.</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1502 Broadway</u>		d. STREET ADDRESS (If outside, give location) <u>8407 Highland</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>RAYMOND ARCHIE FRAZIER</u>			4. DATE OF DEATH Month Day Year <u>1 22 1963</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>5-24-08</u>
9. AGE (last birthday) <u>54</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Garage Supply Clerk U.S. Post Office</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Napoleon, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>William Wright Frazier</u>		13b. MOTHER'S MAIDEN NAME <u>Dora Miranda Moss</u>	14. NAME OF HUSBAND OR WIFE <u>Evabelle Albers Frazier</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	17. INFORMANT Address <u>K.C., Mo.</u> <u>Mrs. Evabelle Frazier, 8407 Highland</u>
18. CAUSE OF DEATH (Enter only one cause, per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia Pneumonia</u> 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) <u>Hurtain Cold Cough several days</u>			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 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 _____, to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>H. H. Owens M.D. Coroner</u>		22b. ADDRESS <u>152 Union Station - K.C., Mo.</u>	22c. DATE SIGNED <u>1-23-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-25-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills Memorial Gdn. Kansas City, Missouri</u>
23d. LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR ADDRESS <u>WEILERT FUNERAL HOMES(S) K.C., MO.</u>	
25. DATE RECD. BY LOCAL REG. <u>1-24-63</u>		26. REGISTRAR'S SIGNATURE <u>Beth Long</u>	

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,

~~by~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Jack J. Moore

Licensed Embalmer No. 4729

P. O. Address Trimbale 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.