

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

19370

791
1003

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City *St. Louis* (No. *City Hosp*)

File No.....

Registered No. *5318*

St. Ward)

2. FULL NAME

(a) Residence. No. *1209 So. 6th* St., *22* Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *8* yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Emma Fraser

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Mar 6 - 1854

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
<i>77</i>	<i>1</i>	<i>28</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Farmer*
(b) General nature of industry, business, or establishment in which employed (or employer) *Retired*
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *Webster Co. Kentucky*

10. NAME OF FATHER

Allen Fraser

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Kentucky*

12. MAIDEN NAME OF MOTHER

Jane Ramsey

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Unknown*

14. HOSPITAL INFORMATION

INFORMANT *Grace Ross*
(Address) *City Hosp*

15. FILED

May 10 1937
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 4th 1937*

17. I HEREBY CERTIFY, That I attended deceased from *May 3rd 1937*, to *May 4th 1937* that I last saw *him* alive on *May 4th 1937*, and that death occurred, on the date stated above, at *7:55 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Chronic myocarditis
Hypostatic pneumonia*
10.3 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTACTED

IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH? *no* DATE OF

WAS THERE AN AUTOPSY? *refused*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical & Laboratory*

(Signed) *W. Schuman*, M. D.

575, 1931 (Address) *City Hospital*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Sr Matthews

May 7 1937

20. UNDERTAKER

ADDRESS

Wacker Helderle

2331 - S. Bleary

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Chapman -