29 1929

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

Do not use this space.
15704

1. PLACE OF DEATH
County Ray Registration District No. 744
Township Richmond Primary Registration District No. 3035
City Richmond P.O. (No. ..... St. ..... Ward) File No. 35
Registered No. 35

2. FULL NAME Perry Monroe Frazer

(a) Residence. No. ..... St., ... Ward. (If nonresident, give city or town and State)
(Usual place of abode) Richmond Mo.
Length of residence in city or town where death occurred 21 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	72	11	2	

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) —
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Rockingham Co. Va.
(STATE OR COUNTRY) Virginia

PARENTS
10. NAME OF FATHER Wm H. Frazer
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Rockingham Co. Va.
12. MAIDEN NAME OF MOTHER Sarah Jane Perry
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) —
(STATE OR COUNTRY) Rockingham Co. Va.

14. INFORMANT J. S. Frazier
(Address) Richmond, Mo.

15. FILED 4/6 1929 E. E. Gay REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 15 1929

17. I HEREBY CERTIFY, That I attended deceased from Mar. 10, 1929 to Apr. 15 1929 that I last saw him alive on Apr. 15 1929 and that death occurred, on the date stated above, at 4:30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CVA Apoplexy
8 days

(duration) ..... yrs. 1 mos. ..... ds.
CONTRIBUTORY (SECONDARY) Cardio Vascular
(duration) 2 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? Home
IF NOT AT PLACE OF DEATH, GIVE ADDRESS
DID AN OPERATION PRECEDE DEATH? No DATE OF ✓
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) E. G. Revare M.D. P.P.
, 19 (Address) Richmond, Mo.

*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
Hickory Grove	Apr 17 1929
20. UNDERTAKER	ADDRESS
Jno W. Kirkpatrick	Hardin Mo

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Ray Registration District No. 744 File No.
Township Primary Registration District No. 3033- Registered No. 33-
City Richmond (No. , St. Ward)

2. FULL NAME Perry Monroe Fravel

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	M.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-13-1856

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
72	11	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. Filed Apr 16, 1929 E. E. Fay. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 15 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19.....
that I last saw h... alive on ....., 19....., and that
death occurred, on the date stated above, at ....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) ....yrs....mos....ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ....yrs....mos....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D.

....., 19... (Address)

*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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

S-15704