

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

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.

NOV 11 1939

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

Do not use this space.

1. PLACE OF DEATH *Ray 2*  
 County *Maize* Registration District No. *914*  
 Township *Maize* Primary Registration District No. *6235*  
 City *Collings* (No. *PA #2*) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 2. FULL NAME *600 Carthana E. Fry*  
 (a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)  
 Length of residence in city or town where death occurred *77* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

File No. *44432*  
 Registered No. *157*

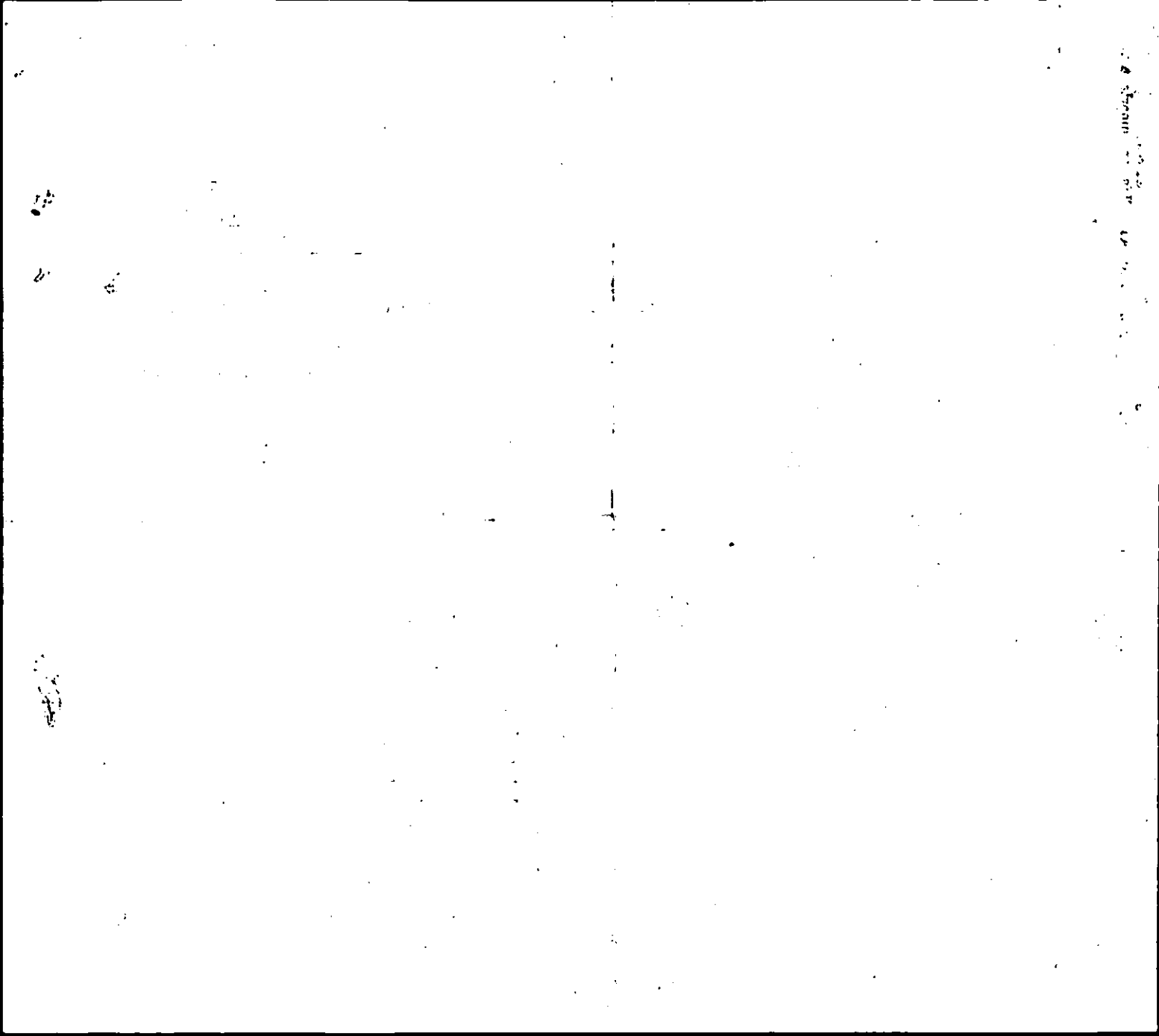
PERSONAL AND STATISTICAL PARTICULARS

3. SEX *FE* 4. COLOR OR RACE *wh* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *John H. Fry*  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *May 8 1*  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
*87 7 4*  
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Housewife*  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year) *Nov 1939* 11. Total time (years) spent in this occupation *70*  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ray mo*  
 13. NAME *Allen, John*  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown Unknown*  
 15. MAIDEN NAME *Caroline Clauson*  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown Unknown*  
 17. INFORMANT (ADDRESS) *John H. Fry, Collings, mo*  
 18. BURIAL, CREMATION, OR REMOVAL. PLACE *Family Burial Yard* DATE *12-14 39*  
 19. UNDERTAKER (ADDRESS) *B & Greal, Maize, mo*  
 20. FILED *Dec 15 1939 Mrs. W.E. Lamb Registrar*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec 12 1939*  
 22. I HEREBY CERTIFY, That I attended deceased from *Nov 16 1939 to Dec 12 1939*  
 I last saw her alive on *Dec 12 1939*. Death is said to have occurred on the date stated above, at *7:30 a.m.*  
 The principal cause of death and related causes of importance were as follows:  
*Basilar Paralysis* Date of onset *9/19/39*  
 Other contributory causes of importance: *Chn. Inst. Nephritis*  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_  
 24. Was disease or injury in any way related to occupation of deceased? *No*  
 If so, specify \_\_\_\_\_  
 (Signed) *C. L. Woolsey*, M. D.  
 (Address) *Raymer mo.*

1870



FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

44432  
Do not use this space.

1. PLACE OF DEATH

(a) County Ray Registration District No. 914  
 (b) Township Scrape Grove Primary Registration District No. 623J  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Parthena C. Fry

(a) Residence, No. \_\_\_\_\_ (Usual place of abode, if no street address, write county or city)  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 8 1852

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
87 7 4

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

FATHER 13. NAME \_\_\_\_\_

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER 15. MAIDEN NAME \_\_\_\_\_

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED Dec. 15, 1939 Mrs. W. E. Part Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 12 1939

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) C. L. Nolsen, M. D.

(Address) Prager

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

