

NOV 21 1930

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

32221

1. PLACE OF DEATH

County ButlerRegistration District No. 89Township Poplar BluffPrimary Registration District No. 3007City Poplar Bluff, (No.)File No. Registered No. 207St. Ward 2. FULL NAME Edmund Frizzell(a) Residence, No. Park Avenue 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

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

Lucinda Frizzell6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 28 1855

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

74

11

22

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Carpenter

(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)

Kentucky

10. NAME OF FATHER

Captain Frizzell

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Tennessee

12. MAIDEN NAME OF MOTHER

Duncan

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

IL

14.

INFORMANT W. A. Bullock

(Address)

Poplar Bluff, Mo

15.

FILED

10-23-3019 30Dr. J. C. Clin

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) October 20th

17.

I HEREBY CERTIFY, That I attended deceased from Oct 15, 1930 to Oct 20, 1930 that I last saw him alive on Oct 15, 1930 and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Concussion of neck
55 ft
4 ft
(duration) 1 yrs. mos. ds.

CONTRIBUTOR (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) W. A. Bullock, M. D.10-23, 1930 (Address) Poplar Bluff, 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

WoodlawnOct 23, 30

20. UNDERTAKER

ADDRESS

Carlos A Greer PoplarBluff, Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EARLY. AGE should be stated EARLY. PHYSICIANS should state EARLY.

**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 Butler

Registration District No. 89

File No.

Township Doplar Bluffs

Primary Registration District No. 3007

Registered No. 207

City Doplar Bluffs

St. Ward)

2. FULL NAME

(a) Residence. No. St. Ward.
(Usual place of abode)

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.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

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**

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

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, hrs.
or min.

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)**

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)**

Unknown

**14. INFORMANT
(Address)**

15. FILED Dec. 30, 1930 B. J. Cline
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Oct 20 19 30

17.

I HEREBY CERTIFY, That I attended deceased from

....., 19....., 19.....
that I last saw h..... alive 19....., and that
death occurred, on the date stated above, at

THE CAUSE OF DEATH WAS AS FOLLOWS:

**CONTRIBUTORY
(SECONDARY)**

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

W. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. 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 COMPLETE AS PRESCRIBED BY LAW

5-32221