

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.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

24396

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Rau Primary Registration District No. 1002 Registered No. 2901
 (c) City Jackson City (d) Street No. St Joseph Hospital 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 33 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Armand Horace Bachman 255
 (a) Residence, No. 7022 Prospect St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE wh. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widower
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 10 1881
 7. AGE YEARS 57 MONTHS 3 DAYS 8 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Street car operator
 9. Industry or business in which work was done, as saw mill, bank, etc. KC. Public Service
 10. Date deceased last worked at this occupation (month and year) May 1937 11. Total time (years) spent in this occupation 22

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Montgomery Co. Mo.

FATHER 13. NAME Unk. Bachman

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER 15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Montgomery Co. Mo.

17. INFORMANT (ADDRESS) Mrs. Dallas Wright 7022 Prospect

18. BURIAL, CREMATION, OR REMOVAL PLACE Forest Hill DATE July 20 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. H. Medicom's Sons Bushcreek + Paseo

20. FILED July 19 1938 M M Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 18 1938
 22. I HEREBY CERTIFY, That I attended deceased from May, 1935, to July 18, 1938
 I last saw him alive on July 18 1938 Death is said to have occurred on the date stated above, at 5:30 P.M.
 The principal cause of death and related causes of importance were as follows:

Chronic Glomerular nephritis
 Diverticulitis, urinary bladder with stones
 Arterio sclerosis
 Uremia
 Date of onset when

Name of operation Suprapubic drainage Date of July 16 1938
 What test confirmed diagnosis? Phalloquin Was there an autopsy? no

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) W. H. Medicom, M. D.
 (Address) 915 Argyle

~~W. A. Stewart~~
Rogyle Berg
Jan 15 1977
1-4

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,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed..... *Nell Carr*

Licensed Embalmer No. *3976*

P. O. Address.....

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 this body is not embalmed, above space should be left blank.