

1939 OCT 12 1939

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

31874
Do not use this space.

1. PLACE OF DEATH
(a) County Buchanan Registration District No. 85
(b) Township St. Joseph Primary Registration District No. 1001 Registered No. 915
(c) City St. Joseph (d) Street No. Missouri Methodist 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 24 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Zephaniah Abraham Black
(a) Residence, No. 1501 Jule St. Joseph, Missouri St.
(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 <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Cora Cynthia Black</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>July 29, 1865</u>		
7. AGE	YEARS <u>74</u>	MONTHS <u>1</u>
	DAYS <u>6</u>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Retired Railroad</u>	
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>Conductor</u>	
	10. Date deceased last worked at this occupation (month and year) <u>1934</u>	11. Total time (years) spent in this occupation. <u>53</u>
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Copper Creek, Iowa</u>		
FATHER	13. NAME <u>Robert M. Black</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown, Iowa</u>	
MOTHER	15. MAIDEN NAME <u>Martha Turner</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown, Iowa</u>	
17. INFORMANT (ADDRESS) <u>Richard F. Black, Moline, Illinois</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Memorial Park Cem.</u> DATE <u>September 7, 1939</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Halter Meierhoffer, 1302 Faraon St., St. Joseph, Mo.</u>		
20. FILED <u>9/17 1939</u> <u>H. M. [Signature]</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) September 5, 1939

22. I HEREBY CERTIFY That I attended deceased from June 5, 1939 to Sept 5, 1939
I last saw him alive on Sept 5, 1939 Death is said to have occurred on the date stated above, at 2:30 a.m.
The principal cause of death and related causes of importance were as follows:
Nephritis (Chronic) Date of onset ?

Other contributory causes of importance: 131 Sept 17 39

Name of operation Cholec Date of no
What test confirmed diagnosis? Cholec 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) [Signature], M. D.
(Address) Central Bldg., St. Joseph

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.

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.....

H. H. Kelly
.....
Licensed Embalmer No. **Mo. 3946**

P. O. Address **St. Joseph, Missouri.**

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.