

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

10189
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. 263
 (c) City St. Joseph (d) Street No. Missouri Methodist Hospt. St.
 (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 Bedford D. Mount
 (a) Residence, No. 9th Street Road & Court Street 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Katie Mount
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 18, 1858
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
81 7 18
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
 9. Industry or business in which work was done, as saw mill, bank, etc. Farming
 10. Date deceased last worked at this occupation (month and year) life 11. Total time (years) spent in this occupation life
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Harrison County Mo.
 MOTHER FATHER 13. NAME William Mount
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Tenn.
 15. MAIDEN NAME Liza Danse
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Tenn.
 17. INFORMANT Mrs. Katie Mount
 (ADDRESS) 9th & Court, St. Joseph, Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Ashland Cem. DATE March 6, 1940

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 4, 1940
 22. I HEREBY CERTIFY, That I attended deceased from Mar. 2, 1940, to Mar. 4, 1940
 I last saw him alive on Mar. 4, 1940 Death is said to have occurred on the date stated above, at 5:15pm.
 The principal cause of death and related causes of importance were as follows:
Myocardial Insufficiency Date of onset ?
Auricular Fibrillation; Arteriosclerosis
 Other contributory causes of importance: Hypostatic pneumonia 2-20-40
 Name of operation none Date of
 What test confirmed diagnosis? Clinical 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?
 If so, specify
 (Signed) A. J. Neath M. D.
 (Address) 6207 King Hill Ave. St. Joseph, Mo.

19. FUNERAL DIRECTOR (NAME) Clark Mortuary
 (ADDRESS) 5025 King Hill Ave.
 20. FILED 3/6 1940 A. J. Neath Local Registrar.

(Licensed Embalmer's Statement on Reverse Side)

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.

50M-9-19-38 I X16605

907/192

201

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 3/4/40

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

Signed Emil Clark

Licensed Embalmer No. 3476

P. O. Address St. Joseph, Mo.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10189
Registrar's No. 263

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 85

Primary Registration District No. 1001

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, give "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Bedford D. Mount

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased. (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 81 Months 7 Days 16 If less than one day _____ hr _____ min.

9. Birthplace. (City, town, or county) _____ (State or foreign country) _____

MOTHER FATHER

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace. (City, town, or county) _____ (State or foreign country) _____

14. Maiden name _____

15. Birthplace. (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof. (Month) _____ (Day) _____ (Year) _____

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 5-29-40 (b) A. J. Nestlebank (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH. Month mar day 4 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Insufficiency
Due to auricular fibrillation
arteriosclerosis

Other conditions Hypostatic Pneumonia
Bronchitis
(Include pregnancy, if within 12 months of death)

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? (City or town) _____ (County) _____ (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____
(c) Means of injury _____

23. Signature C. S. Grant (M. D. or other) _____
Address 6207 King Hill Ave Date signed _____
St Joseph Mo

SUPPLEMENTAL

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

S-10189 1940