

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

**14314**  
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85

(b) Township \_\_\_\_\_ Primary Registration District No. 1001

(c) City St Joseph 3 (d) Street No. State Hospital No. 2 Registered No. 401

(e) Length of residence in city or town where death occurred 4 1/2 yrs. 2 mos. 0 ds. (f) How long in U. S., if of foreign birth? yrs. moa. ds.

2. PRINT FULL NAME Lillian Whitney Uhlinger

(a) Residence, No. 515 N. 7th St 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED (OR) WIFE OF Albert P. Uhlinger

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-5-1872

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>67</u>	<u>6</u>	<u>1</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife

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) 1932 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa /

FATHER

13. NAME George Whitney

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Nebraska /

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown /

17. INFORMANT Records of State Hosp. No. 2, St Joseph (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park DATE April 8th 40

19. FUNERAL DIRECTOR (NAME) FLEEMAN & SON INC. (ADDRESS) ST. JOSEPH, MO.

20. FILE SPN 8 40 W. J. Neel Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-6-1940

22. I HEREBY CERTIFY, That I attended deceased from 7-15, 1939 to 4-6, 1940

I last saw h. ex. alive on 4-6, 1940 Death is said to have occurred on the date stated above, at 9:30 p.m.

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

Cerebral arteriosclerosis  
Arteriosclerotic heart disease

Date of onset ?

Other contributory causes of importance: 95%

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? No

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

(Signed) Sam Neel M.D.  
(Address) State Hospital No. 2, St Joseph, Mo.

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 C. G. Swan.....

Licensed Embalmer No. 4082.....

P. O. Address St Joseph.....

**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.**