

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

24606

State File No. \_\_\_\_\_

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 723

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph  
(c) Name of hospital or institution:  
1116 Dewey Avenue  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 60 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
(c) City or town St. Joseph  
(If outside city or town limits write "RURAL")  
(d) Street No. 1116 Dewey  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. 60 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5  
year 1940 hour 10 minute a. M.

21. I hereby certify that I attended the deceased from 6 May  
1940, to 5 July, 1940;  
that I last saw him alive on 5 July, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia Duration \_\_\_\_\_

Due to Senility and paralytic condition

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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

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? \_\_\_\_\_

23. Signature of Walter Meierhoffer (Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
Signature Walter Meierhoffer (M. D. or other) D.O.  
Address Corby Bldg., St. Joseph Date signed 7-6-40

3. (a) PRINT FULL NAME Harry Hackelman Fleming 455

8. (b) If veteran, name war ✓ 3. (c) Social Security No. none

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

6. (b) Name of husband or wife Ida 6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased July 31 1862  
(Month) (Day) (Year)

8. AGE: Years 77 Months 11 Days 4 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace New Madison Ohio  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Manager Transfer Company

12. Name Milton L. Fleming

13. Birthplace New Madison Ohio  
(City, town, or county) (State or foreign country)

14. Maiden name Mary L. Northrop

15. Birthplace New Madison Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs W. S. Bellairs

(b) Address Webb City, Missouri

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 7-8-40  
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Mora Cemetery

18. (a) Signature of funeral director Walter Meierhoffer

(b) Address 1302 Farson, St. Joseph, Missouri

19. (a) July 8, 1940 (Date received local registrar) (b) W. J. Nestle (Registrar's signature)

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

MOTHER FATHER

8221

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**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 W. A. Kelly

Licensed Embalmer No. No. 3946

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. 24606  
Registrar's No. 723

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 Burgess  
(b) City or town Joseph  
(If outside city or town limits, write "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 \_\_\_\_\_  
In this community \_\_\_\_\_ (Specify whether years, months or days)

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.

3. (a) PRINT FULL NAME

Harry Hackelman Fleming

(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

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

8. AGE: Years 77 Months 11 Days 4 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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) Sept. 5, 1940 (b) H. Mestlebusch (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5 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 Semibulbar and paralytic condition

Due to Following brain surgery to relieve intracranial pressure.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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

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) (e) Means of injury \_\_\_\_\_

23. Signature H. Joseph (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTAL

