

AUG 10 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. **24634**Registration District No. **85**Primary Registration District No. **1001**Registrar's No. **756**

I. PLACE OF DEATH:

(a) County Buchanan
 (b) City or town St Joseph Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
28 25th South 20th St Joseph Mo.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3
 (Specify whether
 In this community 3 weeks
 years, months or days)

8. (a) PRINT FULL NAME William Pfleiderer **456**
 8. (b) If veteran, name war none
 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Amelia Pfleiderer 6. (c) Age of husband or wife if alive 66 years
 7. Birth date of deceased April 5 1872
 (Month) (Day) (Year)

8. AGE: Years 68 Months 3 Days 9 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER { 12. Name Jacob Pfleiderer
 13. Birthplace Wertenberg Germany
 (City, town, or county) (State or foreign country)
 14. Maiden name Katherine Schreiber
 15. Birthplace Wertenberg Germany
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Wm Pfleiderer

(b) Address Easton Missouri

17. (a) burial (b) Date thereof July 16 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blakely Cem near Easton Mo

18. (a) Signature of funeral director Horton Be Gale + Bowman

(b) Address St Joseph Mo

19. (a) 7-16-40 (b) H. J. Nestler
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
 (c) City or town Rural
 (If outside city or town limits write "RURAL")
 (d) Street No. 3 1/4 mi. N. W. Easton Mo.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? 66 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14
 year 1940-9 hour 4:45 minute 45 a. M.

21. I hereby certify that I attended the deceased from 4-27-40
 To July 14 1940, 1940;

that I last saw ~~her~~ alive on July 13, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death

Due to Acute Nephritis
Bad Heart
Tissue Decrea
Duplicated.

Other conditions
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations

Of autopsy

Duration

8 hrs
at least

PHYSICIAN

Underline
 the cause to
 which death
 should be
 charged sta-
 tistically.

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?

85 While at work? (Specify type of place)

(e) Means of injury 5

23. Signature W. J. Howdy (M. D. or other)

Address 222 Logan Bldg Date signed 7/15/40

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 July 14 - 4

Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. 3007

P. O. Address 39 E. 10 St. York

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. 24634
Registrar's No. 756

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, 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 _____ (Specify whether _____)
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 William Pfeleiderer
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 Months Days If less than one day
68 3 9 _____ hr. _____ min.

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

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 there _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Sept. 5, 1940 (b) _____ (Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month July day 14 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 acute nephritis
Bad heart
Essence of adenine
Due to complicated

Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings of operations _____
_____ (Signature)
120

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? _____

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

23. Signature Will H. Brown (M. D. or other) _____
Address St Joseph Mo. Date signed _____

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

SUPPLEMENTARY
SEP - 4 1940
a - Exposed to cold
had habits - short
spoonly regulated
abruptly
Fibrosis

