No. 2
-13-40
17-39
X23159

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

AUG 1 0 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24638

Registration District No. 85 Primary Registration District No. 1001 Registrar's No. 760

1. PLACE OF DEATH:
(a) County BUCHANAN
(b) City or town ST. JOSEPH 3
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: STATE HOSPITAL No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 mos. 3 ds. (Specify whether
In this community 9 mo. 3 ds.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Platte
(c) City or town Co Home
(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 Robert Ferrel 640
3. (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 no inform
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 2 (Month) 2 (Day) 1862 (Year)

8. AGE: Years 78 Months 2 Days 2 If less than one day hr. min.

9. Birthplace no information 9
(City, town, or county) (State or foreign country)
10. Usual occupation Com. Laborer
11. Industry or business
FATHER
12. Name 9
13. Birthplace 9
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name no information
15. Birthplace
(City, town, or county) (State or foreign country)
16. (a) Informant Co Clerk - Platte Co.
(b) Address —
17. (a) burial (Burial, cremation, or removal) (b) Date thereof July 17 1940 (Month) (Day) (Year)
(c) Place: burial or cremation State Hospital Cemetery
18. (a) Signature of funeral director Heaton Bigole + Bowman
(b) Address St Joseph Mo
19. (a) July 17 1940 (Date received local registrar) (b) AJ Westlebush se (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15
year 1940 hour 4 minute 45 A.M.
21. I hereby certify that I attended the deceased from Oct. 12, 1939, to July 15, 1940
that I last saw him alive on " " 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death ~~convulsion~~	~~short~~
~~Due to~~ generalized arteriosclerosis	7
Due to Arteriosclerotic Convulsion	short
Other conditions (Include pregnancy within 3 months of death)	

97

Major findings:
Of operations no operation
Of autopsy generalized arteriosclerosis

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?
85 (Specify type of place)
While at work? (e) Means of injury
23. Signature T. T. O'Dell (M. D. ~~or other~~) M.D.
Address St. Joseph Date signed 7/15/40

(Licensed Embalmer's Statement on Reverse Side)

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 ✓ no embalming, Registered Apprentice No. ✓ working under my personal supervision.

Signed Harold Boorman

Licensed Embalmer No. 3619

P. O. Address St. Joseph, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.