

Registration District No. 85

Primary Registration District No. 1001

Registrar No. 441

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: MO-METH-HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1-WEEK-  
(Specify whether  
in this community OVER-50-YEARS-  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Buchanan  
(c) City or town St Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1007 North 3.7  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) **PRIME** FULL NAME GEORGE-C- DACKSTADER

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

4. Sex Male 5. Color Wht 6. (a) Single, widowed, married Widowed  
divorced \_\_\_\_\_

6. (b) Name of husband or wife Margareta 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased Feb. 1 1861  
(Month) (Day) (Year)

8. AGE: 81 Years 2 Months 25 Days If less than one day hr. min.

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

10. Usual occupation Retired Candy Maker

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

MOTHER FATHER { 12. Name unk

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

14. Maiden name unk

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

16. (a) Informant Mrs. Nellie Williams

(b) Address St Joseph MO

17. (a) burial (b) Date thereof Apr. 28-1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Joseph

18. (a) Signature of funeral director Ray Stamer

(b) Address St Joseph MO

19. (a) 4-28-42 (b) W. H. Hertz  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 26  
year 1942 hour 1:15 minute a.m.

21. I hereby certify that I attended the deceased from 4-17 to 4-26, 1942  
that I last saw him alive on 4-25, 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death Surgical shock  
hypertensive heart disease  
Due to \_\_\_\_\_

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 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) (e) Means of injury \_\_\_\_\_

23. Signature W. H. Hertz (M. D. or other) MO

Address Wayne Bond Date signed 4-27-42

PHYSICIAN

Underline the cause to which death should be charged statistically.

*W. Bruce Craig*

**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..... *John Roy Alton*

Licensed Embalmer No. *2435*

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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 13787

Registration District No. ....

Primary Registration District No. 1001

Registrar's No. ....

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: Mo. Methodist Hosp  
(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 George C Dockstader

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. w

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

7. Birth date of deceased Feb-1- 1861  
(Month) (Day) (Year)

8. AGE: Years 81 Months 2 Days 13 If less than one day \_\_\_\_\_ min.

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

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

11. Industry of 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)  
(Burial, cremation, or removal)

(c) Place: burial or cremation. \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Buchanan  
(c) City or town St Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1017 north 3  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr Day 26  
Year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_  
to \_\_\_\_\_, 19\_\_\_\_

that I have seen him/her alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to surgical shock  
hypertensive heart  
disease; due to high blood pressure

Due to Surgical shock was due  
to operation for removal  
of right testicle

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
4-26-42

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?  
\_\_\_\_\_ (Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

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

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

13787