No. 2
-9-4-41
-17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 13 1942

Registration District No. 85

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23831

Primary Registration District No. 1001

Registrar's No. 710

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 weeks (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County DeKalb 32

(c) City or town Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. .....
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME ALFRED. W. EBERSOLD

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex M O

5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mary Ebersold

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased May 31, 1863 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
79	1	23	..... hr. ..... min.

9. Birthplace Near Chicago (City, town, or county) Ill. 1 (State or foreign country)

10. Usual occupation Farmer

11. Industry or business .....

FATHER
12. Name Henry Ebersold
13. Birthplace Cain (City, town, or county) New York (State or foreign country)

MOTHER
14. Maiden name Julia Fisher
15. Birthplace Ashtabula (City, town, or county) Ohio 1 (State or foreign country)

16. (a) Informant Marvin Ebersold
(b) Address Union Star, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 26, 1942 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove

18. (a) Signature of funeral director Lucile M. Wilson
(b) Address King City, Mo.

19. (a) 7-25-42 (Date received local registrar) (b) Rose Herzog (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24 year 1942 hour 7 00 minute P M.

21. I hereby certify that I attended the deceased from June 22, 1942, to July 24, 1942, that I last saw him alive on June 24, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pneumonia Hypostatic	4 days
Due to Heart Disease Art. Sclerosis	months
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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature Dr D Fuson (M. D. or other) MD

Address St Joseph Mo Date signed 7-25-42

1239

(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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed: Lucile M. Wilson

Licensed Embalmer No. 2830

P. O. Address: King City, 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, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

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BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23831

Registration District No. 85 Primary Registration District No. 1001 Registrar's No. 710

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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 4 wks. (Specify whether years, months or days)
In this community:

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Alfred W. Ebersold
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: Mary
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: May (Month) 31 (Day) 1863 (Year)

8. AGE: Years 79 Months 1 Days 23 If less than one day hr. min.

9. Birthplace: (City, town, or county) Ill. (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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 4 year 1942 at 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

Duration

Due to: Bronchopneumonia
Due to:
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations: 107
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)
(b) 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: O. L. H. Tuson (M. D. or other)
Address Date signed

SUPPLEMENTARY