

No. 5-42
17-3
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24373

State File No. _____

FILED AUG 5 1943

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 754

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: Meth Hosp. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution several days
(Specify whether years, months or days)

In this community abt 50 yrs. (Specify whether 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. 920 ROY
(If rural, give location)

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

3. (a) PRINT FULL NAME NEOMA HAGENLOCHER

3. (b) If veteran, name war WW

3. (c) Social Security No. 2W

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Mar.

6. (b) Name of husband or wife Phillip 6. (c) Age of husband or wife if alive ? years

7. Birth date of deceased May 23 1876
(Month) (Day) (Year)

8. AGE: Years 67 Months 1 Days 5 If less than one day _____ hr. _____ min.

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

10. Usual occupation at home

11. Industry or business _____

12. Name A. F. Malloy

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

14. Maiden name Hannah 9
(City, town, or county) (State or foreign country)

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

16. (a) Informant James B Malloy

(b) Address B St Joseph Mo

17. (a) (Burial, cremation, or removal) B (b) Date thereof June 30 1943
(Month) (Day) (Year)

(c) Place: burial or cremation ashland Cem

18. (a) Signature of funeral director Roy Stawley

(b) Address St Joseph Mo

19. (a) 6-30-43 (b) Rob Henry
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25
year 1943 hour 10 minute 2 M.

21. I hereby certify that I attended the deceased from June 25, 1943 to June 28, 1943;
that I last saw her alive on June 28, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
bronchial
about 3 days

Due to _____

Due to Fracture Humerus

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) 13.1

(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) Means of injury _____

23. Signature Clyton Beck (M. D. or other) MD
Address Welfore Boonville Date signed 7/28/43

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically

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

Dr Clifton Smith

Will

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 Ray Clouney*

Licensed Embalmer No. *2435*

P. O. Address *St Joseph Mo*

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

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

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *106*

Registration District No. *42*

Primary Registration District No. *1000*

Registrar's No. *754*

1. PLACE OF DEATH:

(a) County *Buchanan*
 (b) City or town *(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 years, months or days)*

3. (a) PRINT FULL NAME *Neomi Hagenlocker*

3. (b) If veteran, name war *(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 *(c) Age of husband or wife if alive, years*

7. Birth date of deceased *May 20 (Month) (Day) (Year)*

8. AGE: Years *67* Months *1* Days *(less than one day)* min.

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

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)*

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *June* year *1943* hour *8* minute *M.*

21. I hereby certify that I attended the deceased from *19* to *19* that I last saw him *alive on* and that death occurred on the date and hour stated above. Immediate cause of death *Pneumonia*

Duration

Due to *3 days*

Due to *Fracture of femur*

Other conditions *1800 (Include pregnancy within 3 months of death)*

Major findings: *1800* Of operations *18*

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) *accident*

(b) Date of occurrence *6/17/43*

(c) Where did injury occur? *St. Joseph, Buch., Mo.* (City or town) (County) (State)

(d) Did injury occur in or about home, on a farm, in industrial place, in public place? *Public place*

While at work *10* (Specify type of place) (Meaning of injury) *fall*

23. Signature *Regina Smith* (M. D. or other)

Address *300* Date signed *8/20/43*

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

SUPPLEMENTARY

S-24373