

No. 2
1-1-44
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27672

State File No. _____

FILED SEP 11 1943

Registration District No. 8542

Primary Registration District No. 1001 1000

Registrar's No. 859

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: State Hospital # 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 weeks
In this community Lpi (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 320 NO - 6th St
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7/24/43
year _____ hour 8 minute 30 a M.
21. I hereby certify that I attended the deceased from 7/29/43
_____ 19____ to 7/24/43 19____;
that I last saw him in alive on 7/24/43 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia Duration 4 da

Due to _____
Due to _____

Other conditions Myocarditis, Arthritis
(Include pregnancy within 6 months of death)
Coronary Arterio Sclerosis

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 L. Buchanan MD (M. D. or other)
Address State Hospital # 2 Date signed 7/29/43

3. (a) PRINT FULL NAME Chyde: A. VITT.
3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Genevieve 6. (c) Age of husband or wife if alive 61 years
Birth date of deceased Aug 28 1879 (Month) (Day) (Year)

8. AGE: Years 63 Months 11 Days 0 If less than one day hr. min.

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

10. Usual occupation Restaurant

11. Industry or business retired

MOTHER FATHER { 12. Name George A. Vitt
13. Birthplace Missouri (City, town, or county) (State or foreign country)
14. Maiden name William Belle Nailman
15. Birthplace Iowa (City, town, or county) (State or foreign country)

16. (a) Informant Records State Hospital
(b) Address St Joseph Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/31/43 (Month) (Day) (Year)
(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Horton Reed & Burdick
(b) Address St. Joseph, Mo.

19. (a) July 30 1943 (Date recorded local Registrar) (b) Rose Herzog (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

1233

St Joseph, Mo.

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

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

Joe B. Yoder

Licensed Embalmer No. 4173

P. O. Address 319 S. 10th

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.