

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

27756  
State File No. \_\_\_\_\_  
Registrar's No. 875

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

FILED SEP 11 1943 42  
Registration District No. 1004

Primary Registration District No. 1004-1000

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 No. 2  
(If not in hospital or institution, write street number or location)

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

In this community 7 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME WILLIAM E. PFEIFER

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

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

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, Divorced, Single

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

7. Birth date of deceased unknown  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>unknown</u>				hr. _____ min.

9. Birthplace Livingston County, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farming

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Records State Hospital

(b) Address St. Joseph, Mo.

17. (a) Burial (b) Date thereof 7-31-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chillicothe Cemetery

18. (a) Signature of funeral director Statter Meierhoff

(b) Address 13th & Barren, St. Joseph, Mo.

19. (a) 7-31-43 (b) Rose Hedberg  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston

(c) City or town Chillicothe  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28  
year 1943 hour 2 minute P. M.

21. I hereby certify that I attended the deceased from 7-26- 1942, to 7-28- 1943  
that I last saw him alive on 7-28 1943,  
and that death occurred on the date and hour stated above.

Immediate cause of death Bacteremia

Due to ulceration on left side of body from cavity to below left 2 joint.

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 24a

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 J. H. Monoway (M. D. or other) \_\_\_\_\_

Address State Hospital No. 2 Date signed 7-28-43

Duration 1 week

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

**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.....

*Albert R. Harrington*

Licensed Embalmer No. *3258*

P. O. Address.....

*St. Joseph, Ind.*

**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.**