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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. F 31252

FILED OCT 13 1943 42 ~~85~~

Registration District No.

Primary Registration District No. ~~1001~~ 1000

Registrar's No. 921

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

11
1
7

**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 Hosp #2 9.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 yrs & 2 mos (Specify whether
In this community 3 yrs & 2 mos years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Platte 11

(c) City or town Platte City 7
(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 ✓ 0

3. (a) PRINT FULL NAME Arthur Paul

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 Single

6. (b) Name of husband or wife

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

7. Birth date of deceased age 53 (Month) (Day) (Year)

8. AGE: Years 53 Months ? Days ? If less than one day hr. min.

9. Birthplace Not known (City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Not on our records
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Not on our records
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant State Hospital Records
(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-43 (Month) (Day) (Year)
(c) Place: burial or cremation Hospital Cemetery

18. (a) Signature of funeral director Tracy Barry Funeral
(b) Address 218 South 10th St St Joseph Home

19. (a) 8/25/43 (Date received local registrar) (b) Rose Herzog (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Aug day 19
year 1943 hour 5 minute 5A M.

21. I hereby certify that I attended the deceased from Did not see him alive, to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis both lungs, chronic, Pericarditis with effusion Chronic tubercular peritonitis

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 13 p

Major findings:
Of operations
Of autopsy See above

Duration several years

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 E. H. Magee O (M. D. or ~~other~~)
Address State Hosp #2 Date signed 8-19-43

(Licensed Embalmer's Statement on Reverse Side)

1233

Was not embalmed.

**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 Lou Clark

Licensed Embalmer No. 4216

P. O. Address St Joseph W

**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.**