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

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

10487

BUREAU OF VITAL STATISTICS
FILED APR 3 1944

State File No. _____
Registrar's No. 369

Registration District No. _____ Primary Registration District No. 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 Hosp # 2 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 1/2 months
(Specify whether years, months or days)

In this community same

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(c) City or town K.C. Mo
(If outside city or town limits, write "RURAL")

(d) Street No. 1610 Agnes St.
(If rural, give location)

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

If yes, name country ✓

3. (a) PRINT FULL NAME Albert Waller

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex M

5. Color or race Black

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased 11 - 4 - 1874
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>70</u>	<u>7</u>	<u>22</u>	hr. _____ min. _____

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

10. Usual occupation Custodian of a Church

11. Industry or business ✓

MOTHER FATHER

12. Name ?

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

14. Maiden name _____

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

16. (a) Informant Lewis Waller - brother

(b) Address R. 4 N. K.C. Mo

17. (a) R. (b) Date thereof 3-13-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation K.C. Mo

18. (a) Signature of funeral director H. B. Moore

(b) Address 1820 - E. 10th St Kansas City Mo

19. (a) 3-13-44 (b) Asa Storzog
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 12
year 1944 hour 2:45 minute 45 P. M.

21. I hereby certify that I attended the deceased from 2:45 to 4:50
did not attend him. 19 1944 to 19 1944
that I last saw him never saw him alive or never saw him and that death occurred on the date and hour stated above.

Immediate cause of death probably due to hypostatic broncho pneumonia of short duration

Due to large abscesses on baby - lung

Due to patient attended by Dr. Morrow who is not present today.

Other conditions present today.
(Include pregnancy within 3 months of death)

Duration

short

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings: _____

Of operations _____

Of autopsy no 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? _____

While at work? _____ (Specify type of place)

(e) Means of injury ?

23. Signature E. H. Magee (M. D. or other) MD

Address State Hosp # 2 Date signed _____

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APR 3 1944

1751 9 1 1000

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 F. B. Moore
Licensed Embalmer No. 2410
P. O. Address.....

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.