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FILED SEP 9 1944

Primary Registration District No. 1000

Registrar's No. 884

1. PLACE OF DEATH:

(a) County Washington

(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 1 Mo 20 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lafayette

(c) City or town Corder
(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 A

3. (a) PRINT FULL NAME DETRICH ALPERS

3. (b) If veteran, name war. 3. (c) Social Security No. SSD

4. Sex M 5. Color or Race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife not given 6. (c) Age of husband or wife if alive not given years

7. Birth date of deceased not given
(Month) (Day) (Year)

8. AGE: Years 80 Months ? Days ? If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER { 12. Name not given

{ 13. Birthplace not given 9
(City, town, or county) (State or foreign country)

{ 14. Maiden name not given

{ 15. Birthplace not given 9
(City, town, or county) (State or foreign country)

16. (a) Informant Record Hospital

(b) Address St Joseph Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof SEP 7, 1944
(Month) (Day) (Year)

(c) Place: burial or cremation Corder Mo

18. (a) Signature of funeral director W. H. Baker

(b) Address Wagonville, Mo

19. (a) 9/8/44 (Date received local registrar) (b) Delbert Coker (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 6 year 1944 hour 9-45 minute P M.

21. I hereby certify that I attended the deceased from 9-7 1944 to 9-8 1944 that I last saw him alive on 9-8 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

Due to Arteriosclerosis

Due to

Other conditions (Include pregnancy within 3 months of death) 94a

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature W. H. Baker (M. D. or other)

Address St Joseph Mo Date signed 9/14/44

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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 ^{will be} was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed L. H. Hader
Licensed Embalmer No. 4269
P. O. Address Higginsville, Mo.

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.