

FILED OCT 9 1944
Registration District No.

Primary Registration District No. 1000

Registrar's No. 974

1. PLACE OF DEATH:
(a) County Polk
(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 24 da
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson
(c) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 1811 Myrtle
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ?

3. (a) PRINT FULL NAME CHARLES MAYNEN
(b) If veteran, name war No
(c) Social Security No. No

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 2
year 1944 hour 8-45 minute 0 M.

4. Sex M. 5. Color or race W
6. (a) Single, widowed, married, divorced wid
(b) Name of husband or wife ?
(c) Age of husband or wife if alive 22 years
(Day) (Year)

21. I hereby certify that I attended the deceased from 9-30 1944 to 10-2 1944
that I last saw him alive on 10-2 1944
and that death occurred on the date and hour stated above.

7. Birth date of deceased Aug 22 1870
(Month) (Day) (Year)

Immediate cause of death Hypostatic Pneumonia Bronchial
Due to Red rot and deterioration
Due to Smile Deterioration
Other conditions Smile Deterioration
(Include pregnancy within 3 months of death).

8. AGE: Years 74 Months 1 Days 10
If less than one day hr. min.

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

10. Usual occupation not given
11. Industry or business ✓
12. Name Not given
13. Birthplace not given
(City, town, or county) (State or foreign country)
14. Maiden name not given
15. Birthplace not given
(City, town, or county) (State or foreign country)

PHYSICIAN
Major findings: 107
Of operations 107
Of autopsy 107
Underline the cause to which death should be charged statistically.

16. (a) Informant Reid Hospital
(b) Address St Joseph MO
17. (a) Removal (b) Date thereof 10-3-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Joseph Missouri
18. (a) Signature of funeral director John J. Suel
(b) Address K.C. Mo
19. (a) 10/3/44 (b) Walter Reble
(Date received local registrar) (Registrar's signature)

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) Mean of injury ?
23. Signature BBB (M. D. or other)
Address St Joseph Mo Date signed 10/3/44

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

MOTHER FATHER

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

John P. Sheil

Licensed Embalmer No. 3625

P.O. Address K. C. 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.