

FILED JAN 24 1945

Registration District No. \_\_\_\_\_ Primary Registration District No. 1000 Registrar's No. 28

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 Thrs. 2 mos 16 days  
(Specify whether  in this community unknown 9 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. unknown (If rural, give location) 7  
(e) Citizen of foreign country? no (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME WILLIAM W. BLACK.

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

4. Male 5. Color or race white 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Elie Parker Black 6. (c) Age of husband or wife if alive deceased years  
7. Birth date of deceased 2-23-1871  
(Month) (Day) (Year)

8. AGE: Years 73 Months 10 Days 19 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Railroad & Coal Miner

11. Industry or business Miner

MOTHER FATHER { 12. Name unknown  
13. Birthplace unknown unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name unknown  
15. Birthplace unknown Plaquemine  
(City, town, or county) (State or foreign country)

16. (a) Informant Social Welfare Board

(b) Address St. Joseph Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 15, 1945  
(Month) (Day) (Year)

(c) Place: burial or cremation State Hospital # 9

18. (a) Signature of funeral director Herwan W. S. S. S. S.

(b) Address 1802 Union St. St. Joseph, Mo.

19. (a) 1-15-45 (Date received local registrar) (b) Helen J. Felle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 12 year 1945 hour 10 minute 45 P. M.

21. I hereby certify that I attended the deceased from 9-9- 1945 to 1-12- 1945, that I last saw him alive on 1-12- 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia Duration 8 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 107

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

Address State Hospital No. 2 Date signed 1-13-45

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

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**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..... No Embalming.

Licensed Embalmer No.....

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.**