S. No. 2
M—9-4-41
r. 5-17-39
P I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 12832

FILED APR 24 1945

Registration District No. 7 52 — Primary Registration District No. 1 00 — Registrar's No. 434

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St Joseph Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ In this community 16 yrs 3 mo 19 days (Specify whether years, months or days)

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

3. (a) PRINT FULL NAME: Arthur Condurrie
3. (b) If veteran, name war: —
3. (c) Social Security No. —

4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: Widower
6. (b) Name of husband or wife: Not Known
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: Not Known (Month) (Day) (Year)

8. AGE: Years: about 70 Months: Days: If less than one day ____ hr. ____ min.

9. Birthplace: France (City, town, or county) France (State or foreign country)
10. Usual occupation: Druggist
11. Industry or business: ____
FATHER
12. Name: Not Known
13. Birthplace: " " (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: " " (City, town, or county) (State or foreign country)
15. Birthplace: " " (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs Belle Lewis
(b) Address: 1025 Jefferson KC
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/14/45 (Month) (Day) (Year)
(c) Place: burial or cremation: State Hospital Cem
18. (a) Signature of funeral director: John C. Gaughf
(b) Address: 605 N Bryan St Joseph Mo
19. (a) 4-14-45 (Date received local registrar) (b) Roland O. Fischer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Apr day: 9 year: 1945 hour: 11 50 minute: a M.
21. I hereby certify that I attended the deceased from Apr 5, 1945, to Apr 9, 1945, that I last saw him alive on Apr 9, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Thrombus — Duration
Due to: ____
Due to: ____
Other conditions (Include pregnancy within 3 months of death): ____
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? (Specify type of place)
While at work? ____ (e) Means of injury: ____
23. Signature: Leon L. Smith (M. D. or other)
Address: State Hospital #2 Date signed: 4/9/45

1511 (Licensed Embalmer's Statement on Reverse Side)

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 body was not embalmed, Registered Apprentice No. ....., working under my personal supervision.

Signed: John E. Rupp

Licensed Embalmer No. 3986

P. O. Address St. Joseph, 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.