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ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAY 8 1946

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 464

1. PLACE OF DEATH:

(a) County Buehaver

(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution 1716 Bavanish Ave.
(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution 29 (Specify whether years, months or days) 24 yrs.

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Buehaver

(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 1716 Bavanish Ave.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME FRANK-A-POST.

3. (b) If veteran, name war No

3. (c) Social Security No. 491-09-6746

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Hattie May

6. (c) Age of husband or wife if alive not stated

7. Birth date of deceased March 4 1886
(Month) (Day) (Year)

8. AGE: Years 60 Months 0 Days 12 If less than one day _____ hr. _____ min.

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

10. Usual occupation Cook

11. Industry or business Beacon

MOTHER FATHER

12. Name Frank

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

14. Maiden name _____

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

16. (a) Informant Ray C. Post

(b) Address St. Joseph

17. (a) B (b) Date thereof April 19 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's

18. (a) Signature of funeral director Flower Funeral Home

(b) Address St. Joseph

19. (a) April 23, 1946
(Date received local registrar)

(b) Registrar's signature [Signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16
- year 1946 hour 10:30 minute a M.

I hereby certify that I attended the deceased from Jan 1st 1946 to April 16 1946
that I last saw him alive on April 16 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Angina Pectoris

Due to Coronary Arteriosclerosis of aorta

Due to _____

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

Major findings: _____
Of operations _____
Of autopsy _____

Duration 24 hours

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)
Means of injury _____

23. Signature Loren Beck (M. D. or other) _____
Address St. Joseph Date signed 4/17/46

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

11199

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 Roy Stamer
Licensed Embalmer No. 2435
P. O. Address St Joseph

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.