

FILED MAY 8 1946
Registration District No. _____

Primary Registration District No. 1000

Registrar's No. 413

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:
Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 57 Days
(Specify whether
In this community 57 Days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Nemaha 999
(c) City or town Centralia 14
(If outside city or town limits, write "RURAL")
(d) Street No. None 0
(If rural, give location)
(e) Citizen of foreign country? No 2
(Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Dr Charles Rees Townsend

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ella Hartman 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased October 9 1870
(Month) (Day) (Year)

8. AGE: Years 75 Months 5 Days 25 If less than one day hr. min.

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

10. Usual occupation Doctor and Phys.

11. Industry or business _____

MOTHER FATHER { 12. Name Moses Rees Townsend
13. Birthplace Not Known 9
(City, town, or county) (State or foreign country)
14. Maiden name Ann Eliza Cox
15. Birthplace Not Known 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Ella H. Townsend
(b) Address Centralia, Kansas.

17. (a) Removal (b) Date thereof 4-4-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hiawatha, Kansas.

18. (a) Signature of funeral director Fleeman & Son Inc.
(b) Address St Joseph, Missouri

19. (a) April 12, 1946 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 4
year 1946 hour 6 minute 30 A. M.

21. I hereby certify that I attended the deceased from Feb 27 1946 to April 4 1946
that I last saw him alive on April 3 1946
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Bilateral Pyelonephritis

Due to: Renal Structure of ureters

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

Major findings: _____
Of operations: _____
Of autopsy: _____

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 Charles Greenberg (M. D. or other) 0
Address P. O. Box St Joseph Mo Date signed 4/6/46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

3x

MAR 6 1957

APR 10 1956

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, on 03/07

Registered Apprentice No.

working under my personal supervision.

Signed Robert H. Gyle

Licensed Embalmer No. 3308

P. O. Address St. Joseph, Missouri.

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.