

S. No. 2
M-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 27 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26319**
Registrar's No. **932**

Registration District No. **42** Primary Registration District No. **1000**

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

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 9 Days (Specify whether
In this community Unknown (Specify whether
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. 411 No. 12th. St. 7
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country. *

3. (a) PRINT FULL NAME Anthony Groul
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Male **5. Color or race** White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if _____
alive * years
7. Birth date of deceased April 28 1861
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
85 3 11 hr. min.

9. Birthplace Unknown - Germany //
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business C. B. & Q Railroad

12. Name Unknown
13. Birthplace Unknown Unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Unknown
15. Birthplace Unknown Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Welfare Board
(b) Address 10th. & Olive St.

17. (a) Burial (b) Date thereof Aug. 12, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olivet Cemetery

18. (a) Signature of funeral director Herma W. A. ...
(b) Address 1802 Union St. St. Joseph, Mo.

19. (a) Aug. 21, 1946 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month August day 9
year 1946 hour 5 minute 30 P. M.
21. I hereby certify that I attended the deceased from July 31
1946 August 9 1946
that I last saw h im alive on August 9 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 2 hrs.

Due to _____
Due to _____

Other conditions Another Cerebral Hemorrhage
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy 830
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 W. N. Jacob... (M. D. or other)
Address Kirkpatrick Bldg. Date signed 8-12-46

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 *Elmer Thomas*

Licensed Embalmer No. *2640*

P. O. Address *St. Joseph M*

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.