

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

UNITED STATES BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29616**
Registrar's No. **1056**

FILED SEP 30 1946

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

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:
St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 weeks**
In this community **10 Months** (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. **1708 No. 2nd.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **John I. Nations**

3. (b) If veteran, name war **No.** 3. (c) Social Security No. **499-12-3821**

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 **October 8 1898**
(Month) (Day) (Year)

8. AGE: Years **47** Months **11** Days **9** If less than one day hr. min.

9. Birthplace **St. Joseph Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Mgr. Gas Station**

11. Industry or business **Gasoline**

12. Name **John D. Nations**

13. Birthplace **Atchison Kansas**
(City, town, or county) (State or foreign country)

14. Maiden name **Debora Grant Ingram**

15. Birthplace **Wellsville Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **John D. Nations**

(b) Address **St. Joseph, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **9/20/46**
(Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park**

18. (a) Signature of funeral director **Heaton Beale & Burdman**
(b) Address **St. Joseph, Mo.**

19. (a) **Sept. 23, 1946** (Date received local registrar) (b) **[Signature]** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **17** year **1946** hour **7** minute **15** P.M.

21. I hereby certify that I attended the deceased from **March 14** to **Sept 17**, 19**46**
that I last saw him alive on **Sept 17**, 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac Decompensation**
Due to **Septic arthritis**
Other conditions (include pregnancy within 5 months of death) **300**
Major findings: Of operations _____
Of autopsy **as above**
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 **Louis S. Neidoff, M.D.** (M. D. or other) **0**
Address **825 Charles Street** Date signed **Sept 18, 1946**

34 (Licensed Embalmer's Statement on Reverse Side) **St. Joseph, Mo.**

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

MOTHER, FATHER

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, Raymond H. Merchead

..... Registered Apprentice No.....
working under my personal supervision.

Signed Raymond H. Merchead

Licensed Embalmer No. 4413

P. O. Address 319 So 10th 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.